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Harvard Medical
ALUMNI BULLETIN

Ann Landers (Eppie Lederer) speaks at Alumni Day.
Photo by Jim Bourg

Inside HMAB

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In this issue of the *Bulletin*, Alumni Day and Class Day share honors with the report of a task force, appointed by the dean and chaired by George Bernier '60 on financing a Harvard Medical School education. Of direct interest to the Alumni Council is the administrative response.

Invited by the graduating class to speak at Class Day, Donna Shalala, U.S. Secretary of Health and Human Services, emphasized the commitment to reform that will be required in our health-care system. Martin Samuels, professor and chief of neurology at Brigham and Women's, followed with a provocative discussion of empathy in the patient/doctor relationship. Student speakers Sanjoy Dutta and Stefan Kertesz rounded out the program.

On Alumni Day, under the big tent the topic of the day, "The Responsibility of the Medical School to Society," was moderated adroitly by Dan Federman '53, dean for medical education. Eppie Lederer, a.k.a. Ann Landers, led off with a down-to-earth analysis of what patients want from their doctors, "competence, compassion and last but not least, *time*." Bob Glaser '43B, president of the Alumni Association, followed with a thoughtful reminder of the increasing ethical and social responsibilities of the medical school. After questions from the floor, the symposium continued with Michael LaCombe's '68 highly entertaining thoughts on medical education for primary care. The final speaker, Atul Gawande '94, a senior advisor in the Department of Health and Human Services, presented the Washington view of education of primary care doctors.

Reports of the remaining classes follow, plus a nostalgic note by Crawford Campbell '87 on the last day of residency, poems by Donald Coleman '52 and Sedgwick Mead's '38 close encounter with Saint-Exupéry during WWII. It's a busy issue, but then this is a busy time for alumni.

J. Gordon Scannell '40

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Letters

Prisoners of War

Your recent issue concerning physicians' memories of war was very powerful (Spring 1993). I was struck, however, in reading about the adventures of the first few who arrived to provide care for concentration camp prisoners, that we have a vivid snapshot of a vulnerable mass as seen through the startled eyes of a physician, but no hint of the prisoners' lives. As a prisoner of war in Germany, late in World War II, I thought I might add a few comments from the other side.

The prisoners' nudity and apparent lack of modesty was briefly mentioned in the text and confirmed by two photos. POWs rapidly became hosts to large numbers of body lice. There was little or no access to soap, showers, insecticides or other aspects of modern hygiene. Body lice are very annoying—they tickle, bite and humiliate their hosts, and the bite sites are incredibly itchy. Fortunately they generally live on one's clothing when they are not feeding; they also lay their eggs on clothes, usually in the inside seams. Thus, astute hosts have two strategies for fighting body lice: one is to take off one's clothes frequently and to seek out and kill the lice or their eggs; the other is to go nude, at least part of the time.

I can testify that this anti-louse regimen works quite well. It feels good, it has a positive outcome, and it was one of the few activities we could choose that gave us a small but important increment of control over our own lives.

The prisoners in Dr. McDermott's article were also described correctly as physically weak. How rarely have I seen this adequately quantified. My colleagues and I, captured on January 20, 1945 in the aftermath of the Battle of the Bulge, had on that day been in excellent health—muscular, well-nourished, physically prime infantrymen. By mid-March, on a diet of about 500 to 600 calories a day (one thick slice of whole grain bread, one bowl of a few slices of rutabaga in water, and two or three seed potatoes), we had to pause in climbing the stairs to our barracks. There were three standard-height steps. I knew of no one who could climb all three without resting for 30 seconds or a minute at least once. Those of us who were still alive in April had lost about 30 percent of our body weight—in only three months.

Dr. McDermott mentions that several prisoners dropped dead in line waiting for their first post-liberation meal. Liberating troops or those units who were assigned to providing emergency care to prisoners, in my case and I believe generally, had very limited resources—few personnel, little specialized knowledge, few supplies and little competence to produce and serve large numbers of appropriately nourishing meals.

In my own case, our camp of about 15,000 prisoners was liberated by a small group of tanks (I don't think more than a dozen) making up part of the British 8th Army attack force. The tank crews gave us all or almost all of their field rations, perhaps altogether enough to nourish 30 or 40 men for two or three days.

They drove on and no one else appeared for about three days. Meanwhile we took charge of the German food warehouse and the kitchen facilities, as best skeletal men could do, and succeeded in delivering perhaps double the usual rations. The German staff was, of course, gone. When the more rear echelon troops arrived, they were not equipped to care for us either. But they were, over a period of about two weeks, able to evacuate us to hospitals in England and France. We settled down there to a glorious nine meals a day, perhaps not totally wisely but joyously.

Finally, let me give some life to the crowded conditions alluded to briefly in Dr. McDermott's article. Early in my imprisonment, I was part of a group of about 500 American soldiers who were restricted, during night hours (about 4:00 PM to 8:00 AM), to a totally unfurnished room about 20 by 30 feet across. Since we had no beds or chairs and no one had the strength to stand, we all spent the night lying down in layers about three men deep, since that was all the space we had.

It was agonizingly painful to be on the bottom. The floor was cold concrete; the weight of two people above was unbearable. And people's bony angles—elbows, feet, etc.—were relentlessly stabbing. So each of us would sleep fitfully, briefly and then, on awakening, would, one limb at a time, reach up through the bodies above and slowly insinuate ourselves to the top layer—where everything seemed blissfully soft and free for five or ten minutes. Then we would slowly sink back to the bottom.

Bowel urgency and diarrhea were all but universal. Perhaps two, four or six times during the night, each of us would have to stand and "walk" across a mass of bodies or kneel and crawl—all in all perhaps 2,500 journeys per night. Our sleep was not sound and our rest was not restorative.

Other prisoners, like us in every way, slept on straw with simple blankets in groups of perhaps 50 in duplicate barracks. We believed, but had no power to investigate, that the rules had been imposed on us arbitrarily by the long-resident American prisoners who had been put in charge by the Germans. We believed that their (the Americans') motivation was to demonstrate their awesome power so that

Letters

they could live well, at our expense, without fear of rebellion or retribution.

I have never written about these experiences before but it seemed that someone had to speak from the other side of the fence. It might be worth hearing from the German guards and the American betrayers as well.

Alvin Novick '51

Through a friend of mine, who in turn has a friend who is an alumnus of Harvard Medical School, I received the Spring 1993 issue of the *Harvard Medical Alumni Bulletin* with Dr. William McDermott's "The Aftermath of Surrender."

I myself was liberated from KZ Ebensee on Sunday, May 6, 1945, the last KZ of four others I had been incarcerated in (Buna, Auschwitz, Mauthausen and Melk) since the summer of 1943.

I read the article with great interest and have mailed additional copies to other fellow survivors, friends of mine, in the Czech Republic, Luxembourg, Austria and Italy, all of whom were liberated that Sunday.

I myself was very lucky because I was removed from KZ Ebensee within two hours of liberation because of the few words of English I was able to utter then. So I did not have to endure the miseries that my fellow inmates were to suffer.

McDermott's description of the surrounding areas was "right on," although I only became aware of it many years later when I first returned there. While there, I couldn't care less and was only interested to get through the day I had just awakened into.

A few items are not correct, however. The prisoners worked around the clock. There were two distinct work details; a daytime work detail and a night detail and each were 12-hour shifts. The "Stollen" tunnels, which were dug into the mountains by the prisoners, were meant to house the Peenemunde Rocket Factories (V-1s and V-2s). This was not based on hearsay; actual drawings exist as well as nearly all the meeting notes of all those involved in it.

The bodies that were buried along the road leading from Ebensee to Bad Ischl, along the Traun River, were later dug up again by the townspeople and returned to the area of the former camp, where a portion of that camp had been set up as a memorial and where now exist a number of mass graves. The area that formerly was the camp has been made into a housing tract! The only two things remaining of the camp are a portion of the crematorium and the main gate.

Again, I for one would like to thank Dr. McDermott for having written his article so that people continue to be made aware of the things we had to suffer then, and *that* no revisionist can undo.

Max R. Garcia, architect
San Francisco

Ebensee, Now

I discovered that about two years ago the town of Ebensee started a museum to commemorate the camp. The cemetery McDermott mentions was relocated onto a small section of the former campsite, which otherwise has been used for residential development. Only the original gate to the camp still exists. The words "German Atrocity Cemetery" do not appear anywhere. The country is, of course, still as magnificently beautiful as he found it when he first saw it 48 years ago. The people are open and friendly and there is increasing willingness to face Austrians' part of the blame for the horrors of the past.

Erwin O. Hirsch '46
Kohlstatt, Austria

War in Algeria

I read with interest the Spring '93 issue of the *Bulletin*, which recorded the experience of several fellow alumni in the face of war as well as what happened to those who were dedicated to the attempt to free Israel. It reminded me of an experience I had at the end of the French-Algerian war in Algeria in 1962, which elicited a similar reaction in me.

We were a small group of American doctors from Rhode Island Hospital who had accepted a challenge to work in a small corner of this earth that had been ripped apart for seven years by strife, ignorance, poverty and disease. How unprepared we were for the magnitude of the problem.

There were ten million inhabitants and only 200 doctors in their midst. Hundreds of kilometers separated many patients from medical care. Decent housing, medicine, soap, water and proper foods were luxuries. Disease had to take its natural course and the end results made this quite obvious. Tuberculosis and staphylo-

cocci infections were everywhere. Sanitation to localize these dreaded diseases was unheard of.

Living conditions in the Casbah and outside of the main cities seemed intolerable and yet these people survived, surrounded by sand in which the children played, ate and lived. The food consisted of bread, vegetables in season and at times mutton or lamb.

Cleanliness seemed to be an impossibility as water and soap were difficult to come by. Because of this, abscesses were an everyday occurrence that would recur and recur. Fortunately the antibiotics, when they were available, worked marvelously. Osteomyelitis and tuberculosis of the bone and joints were seen in large numbers. Pulmonary tuberculosis affected 50 percent of the native population. Liver disease was seen in the young and the old.

In spite of all these handicaps the people were wonderful. They tolerated their miseries with stoicism. They were friendly and honest. It was a revelation to learn that these individuals were no more interested in war, boundary disputes, atomic warheads and missiles than we were. Their main interest was to find a way to live, eat and enjoy life peacefully.

After seeing those conditions, I could not help but wonder how man with all this wisdom can allow such conditions to exist anywhere in this world. We spend billions of dollars on the production and maintenance of tools of destruction when we should be devoting our energies and resources to improving mankind.

Anthony V. Migliaccio '28

Unseen Forces

The issue on war (Spring 1993) was tremendous. I've always been interested in war and worried about my capacity for courage. I fully expected to go into combat in WWII, though it was over a month before I turned 18. How is it we can put young men into such horrible situations? And how is it that young men go along with it?

Part of it , I think, is the illusion of immortality or invulnerability that defines the young (and people like Custer). Combat calls for the finest and noblest acts of which we are capable—courage, self sacrifice, love of brother and honor are laudable, however we view war itself. But it also brings out the worst—cruelty, destruction, cowardice, ego and the waste of lives.

Can it be that Jesus was right, and the Quakers and Mennonites when they refuse violent resistance even to acts of cruelty to their own? Was Lincoln (and Lee) right in ascribing the suffering of the Civil War to divine judgment on a nation's wickedness? Lincoln saw slavery and the whip as the sin; Lee, I suppose, saw it as the violation of state's rights. Or, are we like lemmings driven to episodes of destruction and mass suicide by the unseen forces of nature, the consequences of what A.E. Houseman calls a universe that "ails from the prime foundation"?

For the soldier crouching in a shell crater on a blasted battlefield, anything is preferable to the immediate horror—anything, that is, but deserting his friends. Maybe our negotiations for peace should be carried out under fire. Accommodation might be easier, pride less a problem.

George S. Bascom '52

photo by Kent Dayton

Marc W. Kirschner

photo by Kent Dayton

Susumo Ito

What A Time it Was

"It was a very unusual event," said Betty Hay of the reunion for the Department of Anatomy and Cellular Biology, held May 22. "It was a reunion that spanned back through the years, from the era of Fawcett and Greep down through the younger group," added Hay, the Pfeiffer Professor of Embryology and former chair of Anatomy and Cellular Biology.

On July 1, the department merged with the Department of Cellular and Molecular Physiology to create the new Department of Cell Biology. A congregation of the department's past and current luminaries came back to acknowledge all the great work that had originated there.

"The reunion was organized with the basic thought of celebrating our achievements rather than mourning our disappearance," said Susumu Ito, James Stillman Professor of Comparative Anatomy Emeritus, and one of the reunion's organizers.

He along with Jean Paul Revel, A.B. Ruddock Professor of Biology at California Institute of Technology, sent invitations around the world. Over 175 attendees came from around the country and as far away as Australia, Japan, Germany and Argentina.

The reunion started with a day-long scientific symposium. Divided into five components, there were talks on the history of the department, local roots of modern cell biology, extracellular matrix and development, organ biology and teaching in the department.

Speakers included Erik Erikson, who gave a slide presentation on the history of anatomy at HMS; Tom Pollard discussed cell motility; Bjorn Olsen put a cellular biology twist on Steinbeck with a talk entitled "Of Mice and Men"; Dick Coggeshall offered what he had learned from Don

photo by Mark Nathanson

Left:
Don Fawcett and Betty Hay at the Annual Meeting of the American Society for Cell Biology in 1985.

Right:
Dick Coggeshall, Morris Karnovsky and Elio Raviola at the reunion for the Department of Anatomy

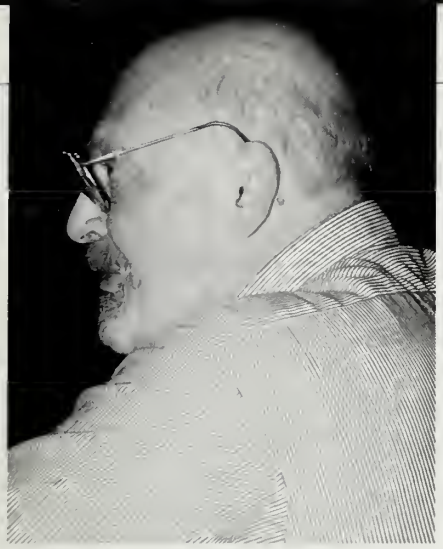


photo by Kent Dayton

Jean Paul Revel

Fawcett; and Elio Raviola talked about "An Excess of Success."

The reunion also served as the setting for the fourth Don W. Fawcett Lecture in Cell Biology, delivered this year by Marc W. Kirschner, PhD, whose lecture was entitled "Cyclins, Centrioles and Cell Cycles." Kirschner, the first HMS Carl W. Walter Professor of Cell Biology, comes to HMS to chair the new Department of Cell Biology from the University of California, San Francisco School of Medicine, where he was a professor in the Department of Biochemistry and Biophysics.

Fawcett '42, who also attended the reunion, is the Hersey Professor of Anatomy Emeritus and former chair of the HMS Department of Anatomy. He recognized early on the potential of the then new technology of the electron microscope in studying cells.

He has maintained his interest in cell function and structure and expanded his focus of investigation first to the male reproductive system and then in 1980 to insect vectors of tropical disease. The latter work took him to Nairobi, Kenya, where for five years he was a senior scientist at the International Laboratory for Research on Animal Diseases. His photography of wildlife from the region has been widely exhibited.

photo by Kent Dayton

HMS Faculty Receive Highest Honors

Seven Harvard Medical School faculty members received high honors in May. Three were elected to membership in the National Academy of Sciences for "distinguished achievements in research," while four others were elected to the Institute of Medicine in recognition of their major contributions to health and medicine.

Faculty members elected to the National Academy of Sciences include: Edward Harlow, HMS American Cancer Society Research Professor of Molecular Genetics and professor of genetics; Peter Howley '72, HMS Fabyan Professor of Comparative Pathology and chairman of pathology; and Joseph Murray '43B, HMS professor of surgery emeritus and chief of plastic surgery emeritus at Brigham and Women's and Children's hospitals.

Those elected to the Institute of Medicine include: Marcia Angell, HMS lecturer on social medicine and executive editor of the *New England Journal of Medicine*; Francis Moore '39, Moseley Professor of Surgery Emeritus; Stuart Schlossman, HMS Benacerraf Professor of Medicine and chief of the Division of Tumor Immunology at the Dana-Farber Cancer Institute; and Glenn Steele, HMS McDermott Professor and chair of surgery at Deaconess Hospital.

Pulse

photo by Holly Compton Alderman

Paul Farmer

Grand Recognition

A highly prestigious MacArthur Fellowship has been awarded to Paul Farmer '90, an instructor in the HMS Department of Social Medicine, who divides his time between the Brigham and Women's Hospital and a rural clinic in Haiti.

Farmer will use the no-strings-attached $220,000 he will receive over the next five years towards the establishment of the Institute for Health and Social Justice to "aid those who help the poor in U.S. inner cities, and any place else where social and political conditions make people sick," he said. His work at the Brigham, where he treats patients with AIDS and TB, and his work in Haiti, where the clinic in which he works treats patients who cannot afford health care, are based on the same principle of helping people who are made sick by the poor economic and social conditions in which they live.

"We usually work in silence, taking care of such people without being able to speak out, much less change the poverty and oppression that make them ill," said Farmer. The MacArthur Award will now give him the "means to address both halves of the problem."

Farmer, who also holds a PhD in anthropology, is the author of AIDS and *Accusation: Haiti and the Geography of Blame* (University of California Press, 1992). He is co-founder of Partners in Health, an organization that develops health awareness programs directed towards Haitians living in the United States. Its sister organization, called Zanmi Lasante and located in Haiti, oversees the rural clinic that Farmer helped found and where he has spent six months of every year for the last 10 years. Zanmi Lasante also organizes community health programs and develops tools such as an HMS education video for women to be used by the health-care workers there.

The MacArthur Fellowship program was initiated in 1981 by the John D. and Catherine T. MacArthur Foundation to "honor creative persons" who are at the "heart of a society's capacity to improve the human condition."

On the Quadrangle

New Director of Alumni Relations

The search committee for the next director of alumni relations didn't need as much time as the Clinton administration to make its nomination, and neither was there a question of confirmation. "Once they realized Dan Federman was an option, the decision was easy," says William D. Cochran '52, chair of the search committee and immediate past president of the Alumni Council.

And as for the reaction of Daniel D. Federman '53 to his selection: "I thought it was terrific. It seemed like a natural expression of my decanal connection between alumni and the school." Federman succeeds William V. McDermott Jr. '42, who retired as of June 30 after two terms as director of alumni relations.

In his role as dean for medical education, Federman (who is also the Carl W. Walter Professor of Medicine and Medical Education), already had a longstanding interest in alumni relations. Now he will be more directly involved in planning the association agenda and activities along with Nora Nercessian, PhD, executive director of the Alumni Association.

Through the years Federman has come to know many alumni—as students whom he taught or advised through the years 1960 to 1990 and others as colleagues he met while traversing the country during the Bicentennial and the regional campaigns. Except for five years spent at Stanford as chairman of the Department of Medicine from 1972 to 1977, he has been at Harvard since his undergraduate days at the college.

Federman, who is an authority on endocrinology and the genetics of sexual development, is known for his clinical insight and eloquence as a teacher. He has been on the staffs of Brigham and Women's and Massachusetts

General hospitals since 1977, is a past president of the American College of Physicians, and is co-founder and co-editor of *Scientific American Medicine*.

Despite the additional work the new role brings to his already title-laden hat, Federman says that he welcomes it because it is an important function. "Everyone thinks of being in medicine as continually learning. In that sense, I'd like to see more connection between the school and its educational role, and alumni."

He says that he came to understand just how actively concerned HMS alumni are about education when the school first started planning the New Pathway, a process in which he was a driving force. He wrote all alumni for advice on what was important in medical education and received over 200 carefully written responses. "These suggestions had a major, by no means intangible, role in planning the Patient/Doctor curriculum in particular."

Federman acknowledges that most people after graduation relate mainly to their own hospital and professional society, "but it has always intrigued me to imagine a continuing connection of graduates with the school. Now I will have the chance to think about this with the Alumni Council."

Does he see any conflict between his role as a dean and as head of alumni relations, which typically has operated independently from the school? "I don't see any conflicts," he answers, "I see a strength. I am clearly connected to the dean and what goes on here, but to me, it's a better opportunity to serve the alumni because of that."

One example of how the connection is a plus, he says, is the alumni-student network, which is being launched in five trial cities. "This is a natural extension of my interest in students and alumni and if it works, we'll expand it."

Another project he envisions for the Alumni Council is to plan a 50-year celebration of the entry of women into the school in 1945. In addition to some sort of celebration, "we would like to work with alumnae on ways the school can better prepare women for the development of their professional careers."

The Alumni Council has been very interested in ameliorating the student indebtedness problem [see task force report in this issue], and as a complement to this, Federman hopes something can also be done to help new alumni—the recent graduates—whose heavy indebtedness may be influencing early career decisions. Another project in which Federman has been involved will certainly help new alumni as residents: the school is starting a pilot course this fall that will teach fourth-year students how to teach.

As for Bill McDermott, he by no means will be retiring completely from alumni relations; he will still report to the Alumni Council in his new role as representative to the Harvard Alumni Association. "It gave me great pleasure and satisfaction to work with Nora," he says about his six years as director. "And I'm delighted that Dan can take this on."

Ellen Barlow

photo by Paula Lerner

Daniel Federman '53 is the sixth director of Alumni Relations since 1952 when Thomas Lanman '16 served until 1961. Lanman was followed by Langdon Parsons '27 (1962-71), Perry Culver '41 (1971-84), William Cochran '52 (1984-87) and William McDermott '42 (1987-93).

On the Quadrangle

And a New Dean

When Peter Nessen, the medical school's new dean for resources and special projects, introduced himself at the June meeting of the Alumni Council, he said that he expected people to react to his being appointed as either a breath of fresh air or with "Why him?" After hearing him speak, however, councillors seemed to agree he was indeed a breath of fresh air.

In fact, as Nessen spoke about what HMS must do to rise to the challenges of financing its plans during this "sea-change in health care," one could almost smell salt in the air. He evoked the image of a tapestry, a fabric he hoped could be woven from now-separate threads—the affiliated hospitals, sponsored research, alumni and public affairs—which could then be presented to potential donors ("stakeholders," he calls them) as one great institution. He is not one to nibble at the solution to a problem; he wants to jump right in.

"The public sees us differently than we do," says Nessen. "They're not interested in cell biology, oncology or genetics; they want a cure for cancer. They won't finance New Pathway or Quadrangle renovations, but they will fund the whole—Harvard Medical School—and then let us facilitate the money to the various needs."

Nessen is a CPA by training who comes to HMS from six years of managing administration and finance for the Commonwealth of Massachusetts under two different administrations (one Democratic, one Republican). A graduate of Dartmouth College (1957) and Tuck Graduate School of Business Administration (1959), Nessen started out at Price Waterhouse and subsequently founded and sold first a consulting firm, then an investment banking firm.

In an interview later in his office, Nessen was asked to define his mission and how it might be different from his predecessor's. He answered that the best way to look at "resources" is to look at the income stream of the medical school. Pull away the tuition, and all other revenue items are his concern, as well as any new resources his staff can create.

He looks for a moment at the giant fish tank that lines one of his walls—something he says he has always had and finds relaxing—and then outlines some of his strategies for finding new prospects for funding. He and his staff plan to look at the readership and memberships of various publications and organizations centered on health issues, and screen for names of those who might have the interest and the net worth to invest in what HMS is about.

"Also, we have never worked with trusts. There's an excess of $50 billion in private charitable trusts that have never been approached by us."

They also plan to better coordinate efforts to tap corporate philanthropy (where there has been success in the past) by "weaving a common theme to leverage interest" among what had previously been separate funding efforts of Sponsored Research, Funds for Discovery and the school's resource and development staffs.

To the alumni councillors, Nessen acknowledged that physicians are worried about their own incomes in these unsettled times "So I can hardly go to you and talk about the needs of the school." Though, as always, the school will be turning to practitioners whose economics are secure enough—most of whom have already identified themselves, he says.

As far as alumni are concerned, he'd like to put aside fundraising for the time being and establish better conduits for face-to-face communication through regionalized networks. He would like the first agenda item for this network to be health forums on the issue of health care reform. "Regional centers could hold panel discussions on the impact of reform ideas on practitioners and health-care delivery."

He believes that an advantage of this would be to have more input on policy issues from "our community of graduates." "Fundraising is an integral part of the institution, but it is only one of many connectors we think should be a standard part of two-way communication with the school. Alumni are our heartbeat."

As for the "special projects" part of his job title, one project has been to promote Harvard Medical School internationally. "We need to develop the ability to look at ourself as the corporate world has looked at itself and export our abilities in different disciplines." There have been many international efforts in the past, "But now we want to coordinate the efforts, leverage them into a theme, with assistance from the affiliated hospitals." He believes that there is a uniqueness about the Harvard Medical Center, which over time, in the spirit of cooperation, he is optimistic can be developed.

On Alumni Day, Dean Daniel Tosteson '48 confirmed that rumors about a university-wide fundraising campaign are in fact true, specifics to be announced later this year. "Solicitations for this will be made

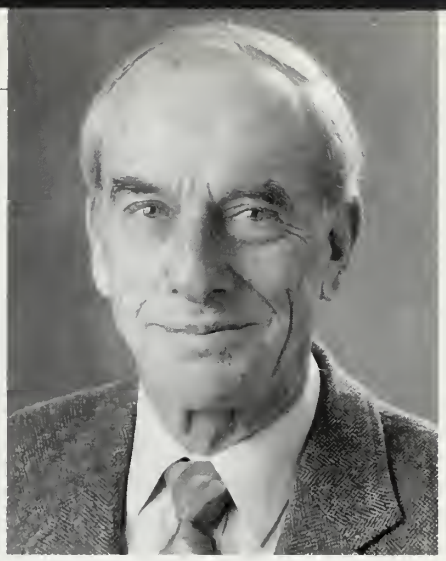
through each of the university's schools and will be part of our campaign," says Nessen.

The way Nessen looks at fundraising is that a major donor is one who has a sense of good will that flows to and from the school. "A gift is one act of many acts representing good will," he says. "Solicitation of funds is a comma, not a period to a relationship, and has to feel good to both the fundraiser and the stakeholder."

Ellen Barlow

President's Report

by William D. Cochran



As my swan song, here's a summation of my brief sojourn as president.

1) Thanks for electing me. My hopes of using the council as a springboard for practicing alumni/ae to get the ear of the dean more easily were muffled by the recent Alumni Council election, in which some of the practicing candidates proposed were outvoted by all of you voting for academic ones! Not the message I was hoping for, but you have spoken as a majority.

2) The council has continued and will continue to push for better student aid (and some of us specifically for lower or at least frozen tuition). This continuing council effort is combined with the report of the Task Force on Financing a Harvard Medical School Education, chaired by George Bernier '60. The report appears in this issue of the *Bulletin* on page 12. Reportedly, one of the 1993 graduates has a debt greater than $150,000!

3) Alumni/ae student networking. Along with the Alumni Office, HMS alumni in five trial cities will host third-year students. It is proposed that third-year students looking at distant residency programs can contact—or better still, stay with—a local alum. The trial cities are Los Angeles, San Francisco, Seattle, Chicago and New York. Feedback will be essential. When all goes well, the program will be expanded.

4) Alumni Day. The focus was the responsibility of a medical school to society. What do patients want in a doctor (and where might we let them down) and how should a medical school respond? Both Bob Glaser '43B and Ann Landers (Eppie Lederer) got the day off to an excellent start. Other alumni (especially Michael LaCombe '68) on and off the podium carried on with enthusiasm and good insights. Atul Gawande '94, a medical student on leave of absence and now working with Clinton's health policy team, had a chance to tell us what he perceived as some of the issues. All in all, very interesting, and hopefully helpful!

Please continue to voice your approval or disapproval. You are heard. Your new Alumni Council president, Bob Glaser '43B, will, I am sure, be insightful in this next year of shifting winds.

William D. Cochran '52 is HMS associate clinical professor of pediatrics and pediatrician-in-charge at the Beth Israel Hospital.

Task Force Report on Financing a Harvard Medical Education

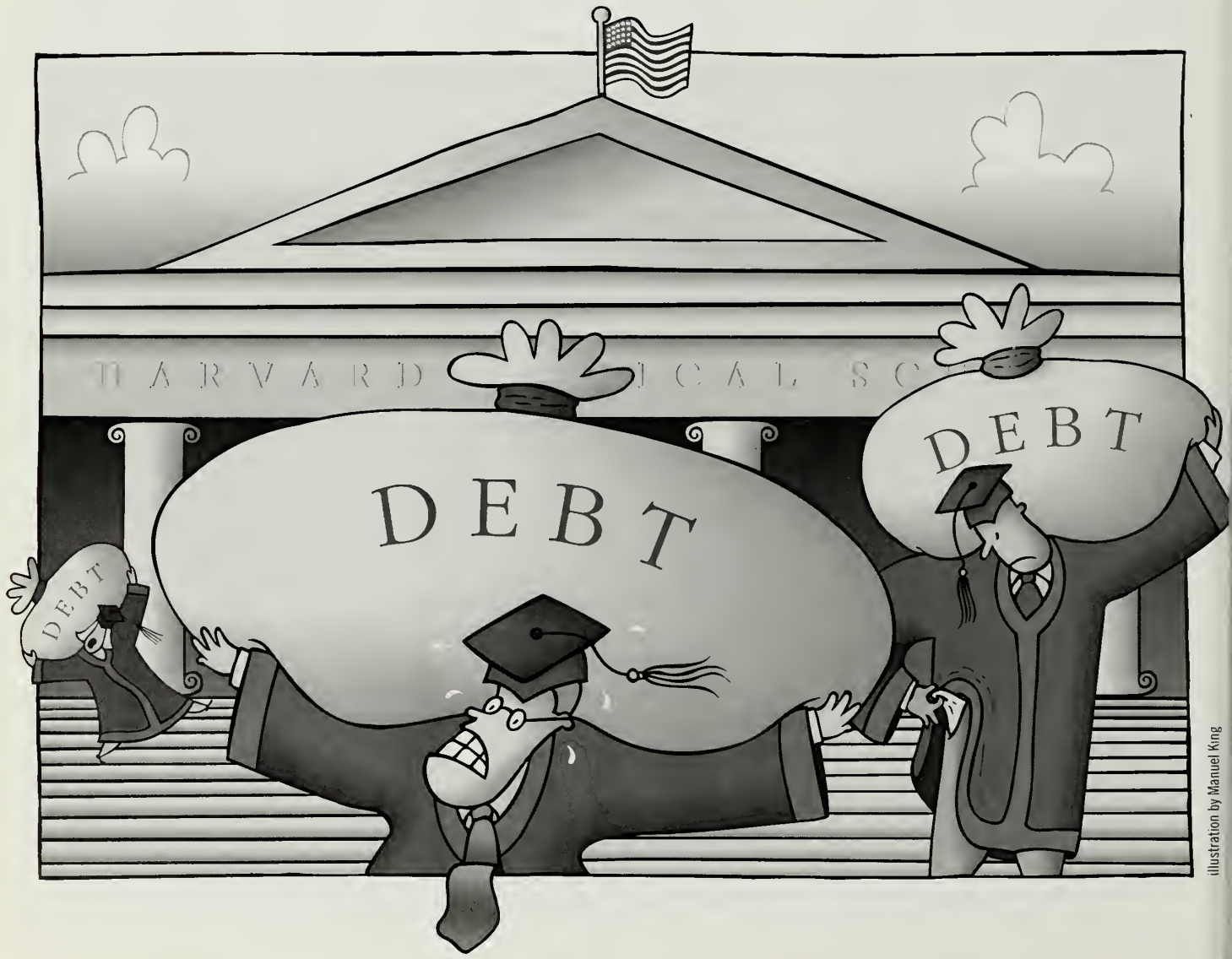


illustration by Manuel King

In June 1991 Dean Daniel Tosteson appointed a task force to examine the problem of the increase in medical student indebtedness at Harvard Medical School. The task force was asked to review the situation and evaluate potential remedies.

Members represented the Harvard Medical Alumni Council, medical school faculty, the business community, local medical community, and the Financial Aid Office of Harvard Medical School. The committee met five times, hearing and discussing reports from the Financial Aid Office, the dean, four current students and committee members. This report reflects the views of the committee about the current financing of medical education at Harvard and its recommendations for change.

The Problem

During the last two decades in particular, tuition at Harvard Medical School, and at most other private medical schools, has outpaced inflation. Increased tuition charges have been met by greater borrowing on the part of the students and, since many students enter medical school with substantial debt from their undergraduate years, the burden of accumulated debt is even greater. For the Class of 1992, the average debt was $51,400, and the recent pattern of debt suggests a significant shift toward the higher end of the debt pyramid—four members of the class graduated with debt exceeding $100,000.

In some ways, these figures understate the magnitude of the problem because they do not factor in the compounding of interest. Once incorporated, the compounding of interest may eventually result in a tripling of actual payback, such that those most indebted could be repaying more than a third of a million dollars when their payment schedules are complete. Moreover, most heavy borrowers must use multiple lending agencies with varying payback schedules, making debt management very complex.

What are the consequences of these staggering debts upon our students? We know that a third of students accepted at Harvard Medical School elect not to matriculate here. In 1992, 47 percent of those choosing to go elsewhere went to public medical schools with lower tuition or to schools that offered a more favorable mix of scholarship and loan, including guaranteed MD/PhD funding. We do not know what fraction of potential applicants are deterred from applying to Harvard because of the anticipated debt burden.

However, applicants to private medical schools (and increasingly to public medical schools) are aware of the debt burden that they face, and the level of future indebtedness must be a factor in deciding whether to attend medical school and what school to choose. Nonetheless, currently enrolled students seem surprised and overwhelmed by the impact of their debts once they experience the reality of borrowing large sums.

Does level of debt influence career choice in terms of specialty training or in relation to site of practice? Societal needs, as enunciated by health policy makers and government leaders, include the overall need for more primary care/generalist physicians and the location of more physicians in underserved rural and inner-city areas. Physician compensation in primary care and underserved areas has historically been far less than for subspecialist practices in urban-suburban hospital-based settings.

It has been hypothesized that heavy debt burdens will discourage students from entering primary care careers or from locating their practices in underserved areas. It has also been suggested that large debts will deter young physicians from careers in basic science research, which would be counter to the social goal of advancing medical knowledge. Although studies to date fail to show a correlation between level

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of indebtedness and the student's career choice, this may be due to the fact that extraordinary levels of indebtedness are largely a recent phenomenon. Committee members have personal knowledge of many students whose decisions about future training were heavily influenced by the magnitude of their indebtedness. Certainly it is hard to imagine a graduate undertaking a practice in a rural primary care setting while shouldering a $100,000 debt.

Another major impact of large educational debt is the psychological one. This was evident in the committee's interviews with students who have large prospective debts and are preoccupied with their financial prospects. This preoccupation achieves a more concrete degree of reality when, during residency, young physicians are required to begin paying back many of their loans while receiving relatively small incomes. A compounding problem then emerges since most highly indebted residents have borrowed from multiple lenders, each with its own payback schedule. For some it becomes a bookkeeping ordeal to maintain payment schedules to avoid default. Many, under severe financial pressure, "moonlight" to make ends meet.

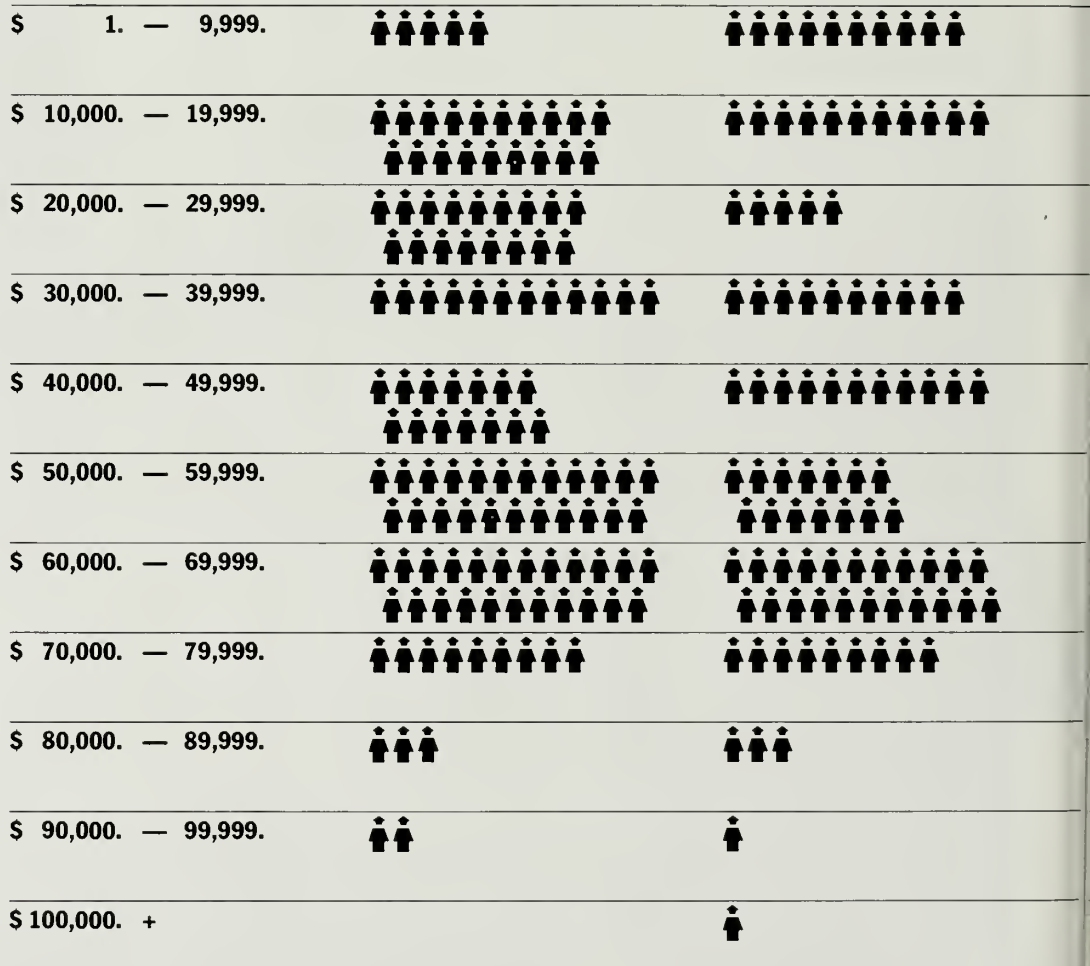
Many students have taken on such high levels of indebtedness with the expectation that inflation and real growth in their future incomes would minimize the consequences of their debt. Recent decreases in rates of inflation and current trends in physician payment reform, however, have shaken these expectations.

Legislative efforts at the national level are addressing the increasing costs and lack of universal access to the nation's health-care system. Implicit in many of the health-care reform plans is the notion that physicians' income will be capped or will decline. The Resource Based Relative Value Scale (RBRVS), which began in January 1992, created a tool for managing physician expenditures. Intended to shrink the

Harvard Medical School Student Indebtness

Number of students graduating with total indebtness in the following amounts, including debt prior to maltriculation.

= one student



	1988	1989
Average debt	$44,337	$46,721
Number of debtors	127	97
Number of graduates	159	141

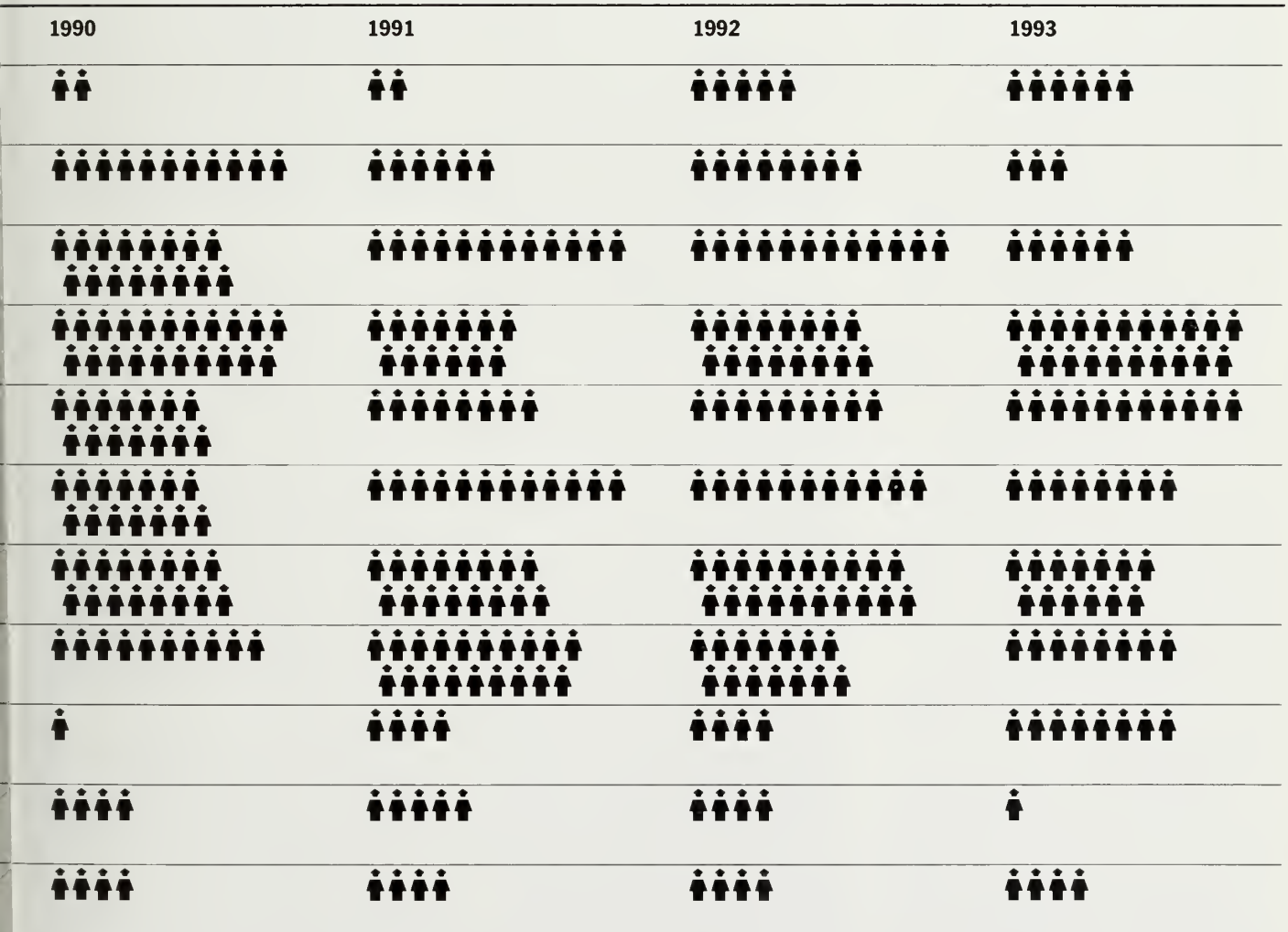
disparity in payment between "procedural" and "cognitive" services, the RBRVS can be expected to lead the way for other health insurers in physician payment reform. As a result, matriculating medical students can anticipate two features of physician payment within the evolving U.S. health-care system: first, future physicians are unlikely to enjoy the same generous level of financial rewards as their predecessors; second, specialty choice will continue to have financial consequences, but not of the same magnitude as in the past.

It is not surprising, therefore, that a growing number of matriculating students are apprehensive about the twin prospects of escalating debt and reduced earning potential.

Current Financial Aid Program at Harvard Medical School—The Unit Loan Concept

The "unit loan" is a financial aid packaging device used to ration scholarship dollars and ensure that Harvard's scholarship funds are directed to those with the greatest financial need. This unit loan packaging concept is employed by most of the 13 schools in the Medical School Consortium. Its implementation, however, may have different outcomes at different schools because of variations in cost of attendance, number of financially needy students, magnitude of aggregate financial need, and quantity of scholarship dollars available.

The unit loan assumes that various loan programs are available for a base level of funding and, therefore, is the threshold of financial need the applicant must evidence before being eligible for Harvard scholarship funds. For example, since the unit loan for 1992-93 is $20,200, a student must demonstrate financial need of $20,300 in order to qualify for $100 of Harvard scholarship. Since no one student loan program can offer an annual loan capacity of $20,200, the unit loan is awarded as a "package" of loan programs; students from the neediest backgrounds are given first access to



1990	1991	1992	1993
$47,357	$54,800	$51,438	$51,774
113	101	107	89
166	161	160	137

the most favorable types of campus-based loan programs. The unit loan increases in amount from one year to the next because of increases in the cost of attendance. The average total cost of attending Harvard Medical School for one year—including tuition, housing, transportation and other living expenses—is approximately $35,000.

Using the unit loan as the basis for financial aid packaging, in 1991-92 the average Harvard Medical School scholarship award was $8,397, with awards ranging from $100 to $15,100.

The Role of Tuition in Financing Harvard Medical School

Tuition represents a small portion of the total income of Harvard Medical School, approximately 5 percent. Only half of that is derived from medical and graduate students; the other half comes from Continuing Medical Education. Since medical student tuition is such a small part of the school's finances, and such a large burden for the student, it might appear logical to reduce greatly or even eliminate tuition.

Indeed, the Mayo Medical School has indicated that it plans to phase in a tuition offset scholarship over a 13-year period with funds derived from other sources (presumably practice income). Tuition at Johns Hopkins increases annually only for the matriculating class; that rate is held constant for the students' continuing years. Some other schools in recent years have held or reduced their tuition. The University of Pittsburgh held its tuition constant for a four-year period (1986 through 1989).

The problem with viewing tuition income as a trivial part of the school's finances is that tuition income is in fact quite critical to the institution. All of the research funding and much of the endowment income are restricted in their uses. Annual giving of unrestricted funds and unrestricted endowment income ($1.66 million and $1.67 million, respectively, in AY92) represents the only other source of flexible funds to support the educational mission of the Harvard Medical School. Conventional wisdom holds that the cost of medical education is two to three times its price, suggesting that a Harvard medical education is a relative bargain.

Notwithstanding the importance of tuition income to the medical school, it is clearly one of the variables that must be addressed in seeking solutions to the student indebtedness problem.

Residency Income

Of the multiple sources of loans for medical students, virtually all require repayment to begin 2 1/2 years after graduation. The table on page 18 shows a "standard case" breakdown of living expenses for a resident earning a starting salary in the low to mid-thirties and bearing a debt of $65,000. In this scenario, the resident would have to devote 35 percent of his/her discretionary income to loan repayment in the first year. The portion of discretionary income spent on debt repayment rises to 50 percent in year two of residency and reaches or exceeds 100 percent in years three through five. Forbearance may be sought and granted through the duration of residency; however, under these circumstances, continued forbearance magnifies the degree of indebtedness.

Many task force members expressed concern about the relatively low salaries paid to residents compared to what the residents contribute to patient care in the hospitals. The contrast between the way business and law reimburse their new graduates versus the way medicine does was striking to the nonmedical members of the task force. Those members felt strongly that a change in the present remuneration system to house staff represents the most important way of relieving the educational debt burden of medical students.

For example, increasing the annual salaries in the "standard case" above by $10,000-$20,000 would enable residents to meet their monthly loan obligations plus make advance payments on their student loans without spending all of their discretionary income on debt repayment.

Conclusions and Proposed Remedies

The task force concludes that student indebtedness is a major problem for both current and future students at Harvard Medical School. The task force recognizes that there is no single solution to this problem; rather, actions in several areas are necessary to effectively address this issue. The task force identified five areas in which remedy can be sought:

- actions by the medical school
- efforts by Harvard Medical School alumni
- changes in support provided during residency
- actions of state and federal government
- a system for loan simplification.

While the charge to this committee was limited to examining the financing of medical education at Harvard Medical School, it is apparent to all committee members that HMS should provide a leadership role in this area.

Controlling Tuition

Since tuition is by far the largest single component of the cost of attending Harvard Medical School, the natural place to begin debt reduction is with tuition. As discussed earlier, tuition income represents a relatively small but critical fraction of the school's income, but is an enormous problem to many students. Although reducing tuition would ease the debt burden of students, it would also compromise the

fragile, unrestricted income stream of the medical school.

Is there merit to controlling tuition by reducing the rate of annual increases to sub-inflationary levels, capping at the present level, or even reducing tuition? We think there is.

If we consider the solution to the student indebtedness problem to be multifactorial, and if multiple players should therefore contribute to the solution, it is important for the other players to see clearly that Harvard Medical School is concerned with the debt burden of its graduates. For Harvard to take the bold step of controlling tuition would be a powerful signal to the other constituencies (alumni, hospitals and government).

A cap on tuition or sub-inflationary tuition growth also should contribute to the discovery of new ways to deal with the cost of medical education. Furthermore, given Harvard's national preeminence in medical education, an impact upon other medical schools might be anticipated.

Generational Transfer

Financial contributions by Harvard Medical School alumni can help relieve the debt burden of current students and recent graduates. Alumni are particularly well suited to respond to this need. Most alumni recall their days at HMS fondly and are grateful for their excellent education and opportunities.

Traditionally, the life of current Harvard medical students has been a concern of alumni, as expressed through their elected representative body, the Harvard Medical Alumni Council. It is likely that alumni will be particularly responsive to the financial plight of current students—more so than other parties, such as public agencies or other potential private donors.

In fact, over the past two years, the problem of student indebtedness has been a priority area for the Alumni Association, which recommended to the dean that he appoint the current task force to study the problem and suggest solutions. Alumni also contribute generously to the school through the Annual Fund. In AY92, a total of $3,086,700 was raised from alumni (including current use unrestricted, current use restricted, endowment, life income, and estate and trust gifts). Donations came from more than 50 percent of graduates, one of the highest proportions of alumni giving to U.S. medical schools.

The task force recommends that the school develop and implement a plan for alumni fundraising, with goals to increase the total amount of annual giving and to use a larger proportion of donated funds for student financial aid. Both goals could be attained by making more explicit links between alumni donations and the relief of student debt burden.

This could be done by permitting alumni to earmark funds for student financial aid and by promoting this theme in fundraising communications. Novel programs might be developed, such as an Adopt-a-Student program, in which a class of alumni might contribute to the education of one or more specific students over four years. These students could be identified to the alumni, and communication between students and donors fostered. The task force also applauds and encourages expansion of current efforts to involve students in fundraising efforts.

The task force recognizes that earmarking funds for student financial aid will reduce the amount of unrestricted monies available to the school unless total alumni giving increases. Thus the task force recommends that the goal of this effort be the expansion of alumni annual giving as well as increasing the share earmarked for student financial aid.

The task force considered tapping individuals and corporations currently contributing to the school. This idea was rejected for two reasons. First, it felt that the amount of money likely to be raised would be low. Second, soliciting these sources for student aid might compete with other fundraising efforts by the Office of Resource Development.

Residency Support

The task force believes teaching hospitals should play a role in easing the burden of medical school indebtedness. It is during post-graduate training that medical school graduates are most affected financially by their medical education debt. During these years they are saddled with debt service requirements that consume a substantial portion of house officer salaries. The financial strains faced by future house officers are likely to grow as graduating medical students take on increasing amounts of debt and as debt payment deferment rules become more stringent.

Teaching hospitals committed to addressing these issues could ease the financial burden on their trainees by increasing house-staff salaries substantially and/or by servicing (e.g., paying the interest on) their trainees' educational debt during residency. Relatively modest salary increases of $10,000-20,000 per year can have a tremendous impact on residents' debt burden.

Teaching hospitals currently receive substantial incremental reimbursement for house-staff training through Medicare and Medicaid programs. The task force is aware that, in most instances, reimbursement is related to historical training costs and, consequently, teaching hospitals choosing to increase house-staff salaries would have to bear the costs of such a program themselves. Nonetheless, the task force believes house staff merit greater reimbursement for the work they perform for their hospital employers.

Action by State and Federal Government

While health care is an issue of increasing priority to federal and state governments, the difficulty of financing a medical education may not be high on their agendas in the midst of

Standard case

Debt burden of typical heavily indebted graduating Harvard M.D. compared to Boston teaching hospital's projected annual salaries.

•

Students unable to service debt in year four at projected salary rates.

Resident salary and budget assumptions			Internship (year 1)	Junior residency (year 2)	Senior residency (year 3)
ANNUAL					
Salary			$34,340	$37,669	$41,208
	Less taxes	Federal	6,290	7,222	8,213
		State	1,793	1,991	2,202
		Social Security	2,129	2,335	2,555
		Medicare	498	546	598
	Less expenses	Rent ($750/month)	9,000	9,000	9,000
		Food (250/month)	3,000	3,000	3,000
		Car ($400/month)	4,800	4,800	4,800
		Misc. ($200/month)	2,400	2,400	2,400
Discretionary income			4,429	6,374	8,440
Student loan service			1,566	3,132	8,424
Advance student payments			0	0	0
Remaining discretionary income			2,863	3,242	16
STATISTICS					
Monthly discretionary income			$369	$531	$703
Monthly loan debt service			131	261	702
Debt service as % of salary			5%	8%	20%
Debt service as % of discretionary income			35%	49%	100%

Standard case plus $10,000 salary increase

Debt burden of typical heavily indebted graduating Harvard M.D.

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Salary increase reduces student debt burden.

•

50% of gross salary increase is used to reduce student loan debt in years 1,2, and 3. 25% of salary increase used in years 4 and 5.

•

100% of SLS loan and 7% of HMS loan repaid by end of second year fellowship.

Resident salary and budget assumptions			Internship (year 1)	Junior residency (year 2)	Senior residency (year 3)
ANNUAL					
Salary			$44,340	$47,669	$51,208
	Less taxes	Federal	9,090	10,029	11,126
		State	2,388	2,586	2,797
		Social Security	2,749	2,955	3,175
		Medicare	643	691	743
	Less expenses	Rent ($750/month)	9,000	9,000	9,000
		Food (250/month)	3,000	3,000	3,000
		Car ($400/month)	4,800	4,800	4,800
		Misc. ($200/month)	2,400	2,400	2,400
Discretionary income			10,269	12,207	14,168
Student loan service			1,566	3,132	6,576
Advance student payments			5,000	5,000	5,000
Remaining discretionary income			3,703	4,075	2,592
STATISTICS					
Monthly discretionary income			$856	$1,017	$1,181
Monthly loan debt service			547	678	965
Debt service as % of salary			15%	17%	23%
Debt service as % of discretionary income			64%	67%	82%

escalating health costs. Still, there are public sector actions that could be taken to help solve the debt problem, while also furthering the social goals of increasing the number of primary care physicians and of physicians practicing in underserved areas. In addition, insofar as high debt levels discourage young physicians from embarking on careers in basic science research, high debts may discourage innovation and scientific advances.

The task force identified the following examples of government actions that could be taken and further recommends that the university take an active role in lobbying state and federal governments for such programs:

•

A change in federal and state tax codes permitting the tax deductibility of student loan interest to relieve the financial burden of recent graduates, who spend a large fraction of their limited resident incomes on debt repayment. This change would also foster the larger societal goal of supporting education of all types.

•

State or federal programs in which government pays the cost of medical education for students who subsequently provide medical care attuned to social needs. This could be done prospectively—tuition paid in

Fellow 1 (year 4)	Fellow 2 (year 5)
$45,812	$50,727
9,502	10,977
2,476	2,768
2,840	3,145
664	736
9,000	9,000
3,000	3,000
4,800	4,800
2,400	2,400
11,129	13,901
13,824	13,824
0	0
(2,695)	77
$927	$1,158
1,152	1,152
30%	27%
124%	99%

Fellow 1 (year 4)	Fellow 2 (year 5)
$55,812	$60,727
12,553	14,077
3,071	3,363
3,441	3,441
809	881
9,000	9,000
3,000	3,000
4,800	4,800
2,400	2,400
16,738	19,765
11,255	10,798
2,500	2,500
2,982	6,467
$1,395	$1,647
1,146	1,108
25%	22%
82%	67%

exchange for future practice of a certain type, as currently exists for the armed services—or it could be done retrospectively, forgiving debt for students who elect to practice in medically underserved areas, pursue careers in basic science research or in other ways address societal needs, similar to the National Health Service Corps. The social goal might be achieved more effectively if done retrospectively.

Loan Simplification

Large educational debt generates complex debt service due to the nature of an intricate multi-loan-source debt portfolio. A young physician's success at managing substantial debt is impeded by the perplexity of dealing with an array of lenders and loan servicers and their accompanying bureaucracies. During residency when the young physician has little time to attend to details of personal matters, the confusion of debt service and forms can lead to peril of technical default. Simplification of the debt management is needed for the young physician to discharge the loan obligations responsibly.

A loan management service would be of great benefit to house staff. The task force suggests that the Harvard Medical Center investigate the feasibility of organizing an office to help house staff and young faculty control the paperwork and financial management associated with their educational loans. Whether such an office should be within the medical school administration or that of the hospitals should be considered. Johns Hopkins and St. Louis University have designated staff and equipment to serve this purpose for house staff in training at their university hospital. Those environments where hospital and medical school are an integrated unit more easily lend themselves to this service centered at the school. Harvard's decentralized environment poses a challenge in this regard.

If, through loan simplification, the number of loan sources were diminished, the payback management, and potentially the financial burden as well, would be reduced. In addition, better management could lead to better information. For example, departments of pediatrics and family medicine in other parts of the country openly advertise competitive "bonuses" or grants to residents for educational loan repayment. The task force regarded this idea as one most easily accomplished.

The committee had hoped to recommend a creative financing mechanism yet undiscovered; it examined existing student loan programs and their terms and conditions to see whether anything of significance could be done, particularly at a time of lower market interest rates, to lower the costs of financing a medical school education.

Our analyses show that lower rates do help some, as does lengthening the terms of repayment. In the case of the Harvard Medical School Revolving Loan (HMSRL), where flexibility is potentially the greatest, changes in rates or terms would require administrative action and could be a zero sum game—i.e., to lower the cost to a student, either new funds would have to be found (e.g., alumni giving), less funds per student made available, or Harvard University would have to be willing to take a lower rate of return. It should also be noted that in all cases except the federal Supplemental Loan for Students (SLS), loans have quite low effective rates of return to the investor when all the terms of repayment are considered.

It is true that some relief is available to students through current lower market interest rates, but the benefit is modest because only a small portion of the students' portfolio is on a variable rate basis. HMSRL rates could be lowered and might well be if Harvard's required return also drops in a low inflation/low rate environment; however, HMS already makes funds available to its students at a very low effective rate. Extending the term of loans also gives some relief to the student but, without new "sources," reduces funds available for HMS to lend to students in future years.

Thus, tinkering with the terms and conditions of various financing vehicles produces some benefit, but the overall student debt is too large for these mechanisms to be of significant help in reducing the burden of the average student.

Conclusion

The task force views the increasing levels of medical student indebtedness at Harvard and at medical schools across the nation as a serious and escalating problem. Given the magnitude of the problem, no single action will provide remedy. However, smaller actions at several levels can, in the aggregate, help students. We offer a series of potential solutions to Harvard's problem, which would require actions by Harvard Medical School, its alumni and its affiliated hospitals, and federal and state health policy initiatives. We have no doubt that our students and our nation face a crisis, and based on our deliberations we offer a prescription for change.

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Harvard Medical School should avoid worsening the current situation by capping tuition at current levels, or at the very least, reducing the rate of increase to subinflationary levels. Serious consideration should be given to whether tuition might even be reduced.

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The medical school should develop and implement a plan for alumni fundraising that would (1) increase overall annual giving and (2) earmark a greater proportion of funds for student financial aid. New programs to more closely connect alumni with individual students, such as a class Adopt-a-Student program, should be developed.

•

We recommend that hospitals increase resident salaries and/or pay the interest on trainees' educational debt during training.

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Federal and state governments can provide relief in ways that also achieve social goals of promoting education and encouraging physicians to become generalists, to practice in medically underserved areas, or to pursue careers in basic science research. Specific actions include: (1) altering tax codes to permit tax deductibility of student loan interest and (2) developing programs of loan forgiveness for medical school graduates who elect careers that are consistent with the nation's needs for health manpower.

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A loan management service, based either at the medical school, or more practically at the Harvard Medical Center, could ease the administrative burden of loan repayment and help prevent defaults.

Response from Dean Daniel Tosteson '48

I am pleased to have this opportunity to respond to the report of the Task Force on Financing a Harvard Medical Education. I commend the task force members for their hard work and for their thoughtful approach to the very difficult issue of medical student indebtedness. I offer special thanks to George Bernier '60 for his leadership in chairing the task force and for contributing his special insights as dean of the University of Pittsburgh school of Medicine.

As I noted in my original charge to the task force two years ago, concerns about student indebtedness are shared by alumni, students, faculty and administration. No other issue related to our medical education program troubles me more, and it is small consolation that this is an issue of deep concern for medical schools throughout the country.

I endorse the task force's view that there is no one solution to the problem of medical student indebtedness. Rather, it is a multi-dimensional problem that demands a multidimensional set of remedies. The task force identified five primary areas in which remedial activity should occur, and I will comment on each of these below.

Controlling Tuition

The report recommends capping tuition or reducing the rate of annual increase to sub-inflationary levels. While I appreciate the suggestions of the task force on this issue, I do not believe that we are in a position to cap tuition at the present time. We are committed, however, to working towards limiting increases to inflationary and as soon as possible, sub-inflationary levels. Tuition income, while a small percentage of total income to the school, is extremely precious because of its unrestricted nature.

In addition to providing a partial offset (about one-half) to the real costs of our undergraduate medical education program, tuition income serves as a primary source of funding for new educational programs. Tuition income also provides the school with resources to respond to new and emergency needs. For example, the federal government recently enacted new financial aid regulations designed to promote growth in the numbers of medical students who choose careers in primary care. While this is a laudable goal, the new regulations require students to commit to primary care early in their undergraduate medical education in order to be eligible for federally sponsored aid. Students who commit to primary care early on but later change their minds about career choice face significant financial penalties.

Medical schools that cannot demonstrate the commitment of significant percentages of their students to primary care careers face a reduction in federal funding for their financial aid programs. We estimate a loss to HMS of approximately $160,000 annually in scholarship support for minority and disadvantaged students and approximately $400,000 annually in funding for our loan program. Unrestricted income from tuition and alumni giving will allow us to maintain our current financial aid program while we devise a strategy to address the new scholarship and loan program requirements in the long-term.

As a first step in controlling tuition,

we have been able to reduce the rate of annual increase in our tuition charge for 1994. Tuition will increase by only 5 percent this year, representing a drop from increases of 7 percent in 1990 and 1991 and 6 percent in 1992 and 1993. I would also like to point out that HMS tuition is at the median for private medical schools in this country—a fact that is often forgotten as we struggle to find ways to reduce the debt burden of our graduates.

Finally, our commitment to controlling tuition is coupled with a commitment to reducing administrative costs wherever possible. In fiscal year 1993, we reduced our administrative staff by 40 positions, or approximately $2 million, and we launched a number of initiatives designed to improve administrative efficiency throughout the school.

Alumni Fundraising

As the task force report notes, HMS alumni contribute generously to the school's annual fund, with donations last year coming from more than 50 percent of graduates, one of the highest proportions of giving among U.S. medical schools. I am persuaded by the report, however, that we must work harder to increase annual giving overall while targeting a greater portion of contributions for student aid. I welcome the opportunity to work more closely with alumni to achieve these goals, and I share the task force's belief that alumni are more likely than others to donate funds for the explicit purpose of relieving student debt burden.

I have asked Peter Nessen, our newly appointed dean for resource development and special projects, to pay special attention to this issue. In a recent meeting with the Alumni Council, Peter identified a number of preliminary fundraising strategies and received additional helpful suggestions from alumni. He brings tremendous vision, energy and creativity to his new role, and I am confident that we will be successful in developing innovative resource development initiatives under his leadership.

In addition to increasing support for medical students, I am anxious to identify funds to support students working on joint degrees. These include MD/PhD students, our physician-scientists of the future, as well as those studying for MD/MPH and MD/MPP degrees. Students in these latter programs are likely to pursue careers working with underserved populations and/or on health-care policy issues of national concern. We are committed to strengthening these programs and increasing the numbers of students attracted to these areas. In order to be successful in this endeavor, we must be able to identify sources of financial support for qualified students.

Residency Support

While I endorse the task force's recommendations in this area, I regret that implementation will be difficult in the current economic climate. Teaching hospitals are under tremendous pressure to reduce costs in response to a variety of health-care reform initiatives. As a result, a number of teaching hospitals here in Boston recently announced plans to lay off large numbers of clinical and support staff. Nevertheless, I am working with my colleagues in the hospitals to make sure that members of Congress and the Clinton administration are fully informed about the special problems faced by teaching hospitals.

Action by State and Federal Government

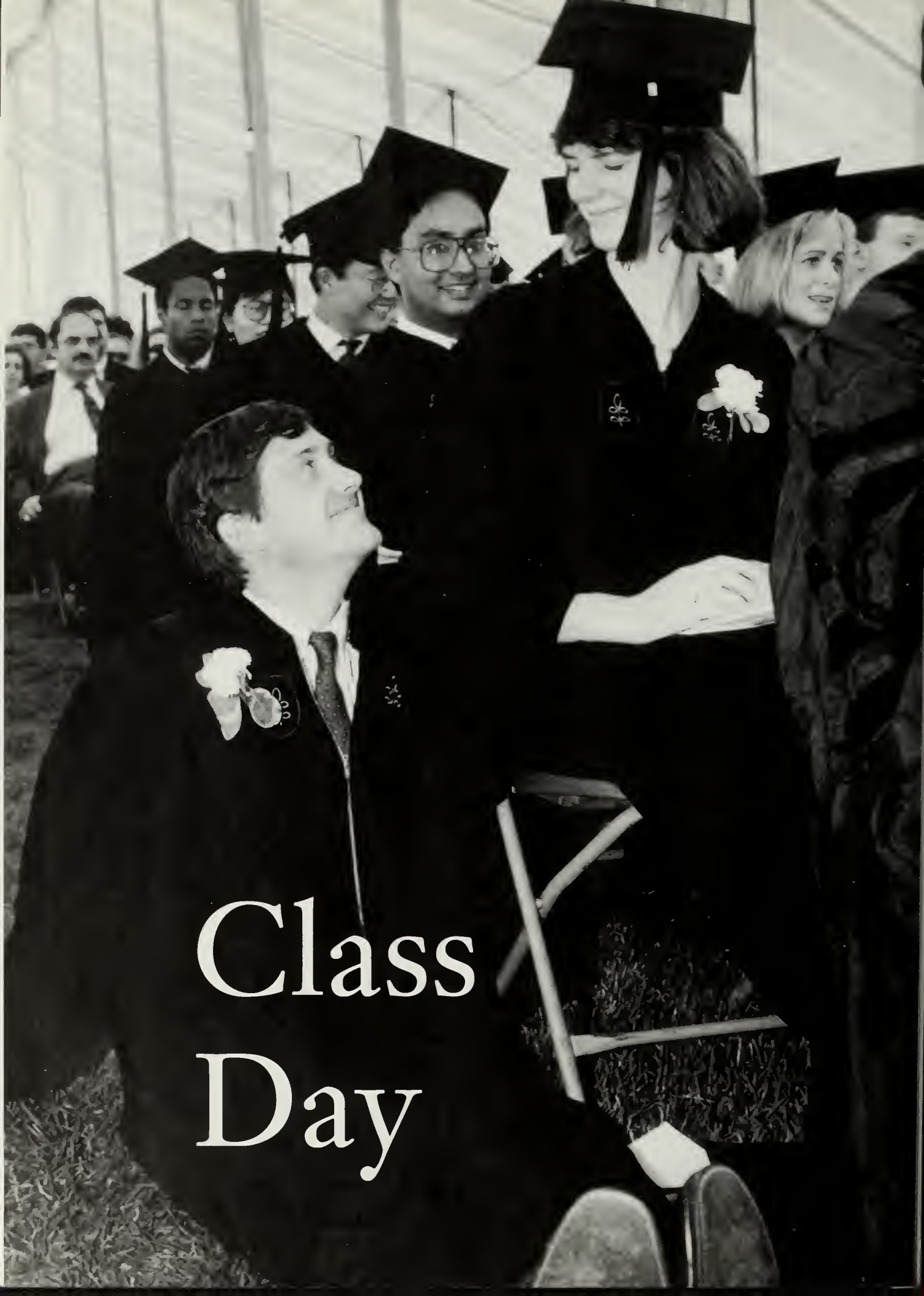
We are working with the Harvard University Office of Government, Community and Public Affairs to inform them about the student indebtedness issue and to enlist their support in working for tax code reform and the development of new programs of student loan forgiveness. Similarly, we will be working with the AAMC and other interested groups to push for changes such as those recommended in the task force report. As an example, last year we were able to play a role in delaying full implementation of the new financial aid regulations described above.

Loan Management Service

At its meeting in December 1992, the Harvard Medical Center (composed of HMS and our primary teaching affiliates) identified the potential value of a debt management office to serve house staff of the member institutions. The group expressed genuine concern for the plight of young physicians who must manage complicated debt arrangements while in the throes of graduate training. Although intrigued by the concept of a centralized debt management office or service, HMC representatives were not sure if our very large and decentralized system of affiliated schools and hospitals would lend itself to this approach.

As chair of Harvard Medical Center, I have asked HMS staff to investigate what other schools and hospitals throughout the country have done to address this issue. The HMC group will hear the results of this investigation at our fall meeting. Although this initiative requires support and commitment from our affiliated hospitals, I believe that the school is in a unique position to provide leadership on the issue, and I am optimistic that we can identify an approach to this problem that will meet the needs of all parties.

In conclusion, allow me to reiterate my thanks to the members of the task force for their hard and dedicated work on the important issue of medical student indebtedness. Although we are not able to implement all of the report's recommendations immediately, we will continue to look for ways to implement them during the coming months and years. I welcome the support of all alumni in this endeavor, and I look forward to the opportunity to report on our progress from time to time.



Class Day

With the fanfare of Hollywood celebrities on the night of the Academy Awards, the Class of 1993 descended the steps from Building A to be greeted by their own adoring fans. Scores of friends and loved ones crowded into the tent's narrow entryway, clutching everything from disposable 110 cameras to sophisticated 35mm ones to sleek camcorders. It was a day absolutely fit for a star.

According to student co-moderators Robert Vonderheide and Gretchen Fisher, Edward Hundert '84, associate dean for student affairs, had specifically requested good weather for the day. The two obliged with a gorgeous warm, slightly breezy day. "We're overachievers," said Vonderheide.

Guests spilled out into the sunshine and even sat along the stone walls lining the Quadrangle. The tent, large as it was, wasn't big enough to contain the swell of energy and excitement of this gala event.

The first HMS student to speak was Stefan Kertesz, who encouraged his classmates to award themselves not for being great researchers or clinical heroes, but because "what most of us did, most of the time was harder than that. ...what we did was show up and give our best effort, even when no one noticed." What everyone receiving a medical degree had mastered, said Kertesz, was the courage and the "art of being there."

In reflecting on what he and his classmates had learned in four years of medical school, Sanjoy Dutta drew good-hearted cheers and applause during his address when he talked of how his class had progressed from saying "I don't know," to "We don't know." Finally they realized that "we cannot hope to have answers to every improbable and esoteric medical question." In the end, he said, they had become "married" to medicine, and as with all lifetime commitments, this relationship brought with it a range of emotions, from frustration and embarrassment to hope, excitement and wonder.

A change in seating arrangements allowed husband and wife graduates Caleb King and Louise Rambo King to sit together.

Faculty speaker Martin Samuels, HMS professor of neurology and chief of neurology at Brigham and Women's Hospital, described the development of his own consciousness during the 1960s. He asked the graduates to take a message from the rock opera *Tommy*, and look outside themselves—at their patients—for insights into the development of their own consciousness: "Imagine yourself as the patient. ...All of the important questions that we need to address as doctors are posed by our patients if only we put ourselves in their places." Samuels closed his address with the music from the opera's chorus—the patient talking to the physician: "See me, feel me, touch me, heal me."

Donna E. Shalala, secretary of Health and Human Services, addressed the current crisis in the U.S. health-care system, calling it an "American tragedy" that 50,000 people a day lose their health insurance and that one-year-old children don't receive polio vaccinations. The Clinton administration has a mandate, she said, to reverse this situation to create peace of mind through "comprehensive change." At this crossroads of American health care, she said, we "dream of a strong health-care future [and] we cannot get there without you."

Vonderheide and Fisher also presented faculty awards to some "totally awesome" teachers. The award for "most outstanding preclinical instructor" went to Steve Weinberger for his "totally awesome textbook, *Principles of Pulmonary Medicine*. Martin Samuels was commended for realizing that "sometimes a laugh is needed in medicine" and received the "most outstanding clinical instructor" for being a "totally awesome teacher." Edward Hundert received an award for being the "faculty memeber who has done most for the class," and for being an "all around totally awesome dean."

The moderators also paid tribute to one of their own who was not able to share in the day's celebrations. Faith Van Nice, who died earlier this year, had successfully completed all the requirements for her medical degree, which was presented to her husband, Bruce Hunter.

"This year I hope for you a profound and proud humility," said Dean Daniel Tosteson to the class, as he initiated the conferring of degrees. While children played in the sun outside the tent, and family and friends lined the sides with cameras ready, the Class of 1993 held their hoods and queued towards their society masters, who arranged them around their shoulders.

This year's class were handed their diplomas from a brand new wooden box—a gift from Timothy Hullar '96 and a marked improvement from the cardboard boxes of yesteryear. This is the first year to present graduate degrees of medical sciences—to 11 Markey scholars from the Division of Medical Sciences.

The Class of 1993 had fifteen students graduate cum laude; six graduate magna cum laude; and one, summa cum laude. The recipients of special awards are:

Andrew E. Budson, cum laude
"In Vitro Studies of the Novel Angiogenic Inhibitor, AGM-1470"

Christopher W. Crenner
Richard C. Cabot Prize for the best paper on medical education or medical history: "Doctoring: Medical Measurement, Urban Specialization and the Movement of Patients in America, 1880-1920"

Bradford Curtis
Dr. Sirgay Sanger Award for excellence and accomplishment in research, clinical investigation or scholarship in psychiatry: "A Psychiatric Case Study"

William C. Faquin, magna cum laude
"Effect of Inflammatory Cytokines on Hypoxia-Induced Erythropoietin Production"

Mark D. Fleming, magna cum laude
Harold Lamport Biomedical Research Prize for the best paper reporting original research in the biomedical sciences: "Dominant Negative Mutants of Transcription Factor mXBP1"

Steven Joel Frucht, cum laude
"The Deposition of ß-Amyloid in Alzheimer's Disease"

Kathryn A. Glatter, cum laude
"A Novel, Clinical Paradigm of Sustained Volume Expansion: Evidence for the Interaction of Volume, the Endogenous Pump Inhibitor and Human Hypertension"

Zachary L. Gleit, cum laude
"Regulatory Elements in the Proximal Promoter Region of the Mouse E-beta Gene"

David E. Goodman, cum laude
"Objective Assessment of Metered Dose Inhaler (MDI) Technique in Patients with Asthma and Chronic Obstructive Pulmonary Disease (COPD)"

Samuel S. Hahn, cum laude
"The Effects of Low-Density Lipoproteins on Extracellular Matrix mRNA Expression"

Chi-yuan Hsu, cum laude
"Orificial Surgery, A History"

Stamatina Kaptain, magna cum laude
Henry Asbury Christian Award for notable scholarship in studies or research: "The Isolation and Characterization of an RNA-Regulatory Protein: The Iron-Responsive Element Binding Protein"

Valerae O. Lewis, cum laude
"Inhibition of Corneal Angiogenesis"

Dean W. Martin, cum laude
"Computer-Derived Density Spectral Array Does Not Reliably Detect Mild Analog Electroencephalographic Pattern Changes of Cerebral Ischemia During Carotid Endarterectomy"

Michael E. Ming, cum laude
"Genetic Analysis of a 60kD Protein Suggests Keratin-10 is Cross-Linked into the Cornified Envelope of Murine Keratinocytes"

Brian Labow and friend walk across the stage to receive their degree.

William T. Pu, summa cum laude
Leon Reznick Memorial Prize for excellence and accomplishment in research: "Mutational Analysis of the bZIP DNA-Binding Domain of GCN4, a Yeast Transcriptional Activator Protein"

Evan Reiter, cum laude
"The Effect of Olivocochlear Efferent Stimulation on Auditory Threshold Shifts Induced by Intense Tone Exposures"

Thomas J. Schuetz, cum laude
"Identification of Transcriptional Activation Domains in the Human Heat Shock Factors"

Theodore H. Schwartz, magna cum laude
"Lateralization and Timing of Neuronal Activity in Human Lateral Temporal Cortex During Overt and Silent Naming and Reading, Rhyming, Line-Matching and Naming in Multiple Languages"

Nathan R.W. Selden, cum laude
"Human Striatum: Chemoarchitecture of the Caudate Nucleus, Putamen and Ventral Striatum in Health and Alzheimer's Disease"

Robert H. Vonderheide, magna cum laude
James Tolbert Shipley Prize for excellence and accomplishment in research: "Identification and Molecular Analysis of Very Late Antigen 4 Counter-Receptor"

Yaffa K. Weaver, cum laude
"A Variable Repetition Rate Picosecond Nd:YAG Photodistruptor for Precision Intraocular Microsurgery"

Christopher I. Wright, magna cum laude
"The Selective Inhibition of Cholinesterases in the Histopathological Structures of Alzheimer's Disease: Indolamine and Protease Inhibitor Effects"

Justin S. Wu, cum laude
"Laryngeal Allograft Transplantation"

Students who have received other degrees while at Harvard Medical School or are candidates in June 1993:

DOCTORS OF PHILOSOPHY:
Christopher William Crenner
David Huang
Pedro Enrique Huertas
Michael Patrick McCue
Terrance David Sanger
Thomas Joseph Schuetz

MASTERS OF PUBLIC HEALTH:
Samuel R.G. Finlayson
Gayla Goode Sylvain
Michelle Susan Weinberg
Persis Oneeka Williams

MASTERS OF PUBLIC POLICY:
Damien Antione Doute
Steven G. Gordon
Elizabeth Anne Howell

Health Care at a Crossroads

by Donna E. Shalala

I WANT TO CONGRATULATE EACH AND every one of the graduates. Each of you has succeeded with your own special flair, and we are all very proud of you. We also should express gratitude to all the loved ones on whose strong shoulders you stand today, so proud and so accomplished.

I want to begin by telling you about a cartoon that appeared recently in the *New Yorker*. A little girl and boy are pictured together, and the boy has evidently just made the age-old suggestion to the girl that they "play doctor." The girl responds, "Ok, you be the doctor, I'll be the Secretary of Health and Human Services." Well, you're the doctors—and the dentists—and I'm the secretary.

We're coming together today as America reaches a crossroads in the history of our health-care system. And the question before us is very simple: which road are we going to take?

Are we going to continue on the reckless course that we've followed for too long now—skyrocketing health-care costs, mounting numbers of uninsured patients, a barrage of paperwork for doctors, and a widespread fear that most Americans are one step away from losing their coverage and their security? Or are we going to have the courage to blaze new trails—to begin to build a new system that finally enables all Americans to have caring and supportive relationships with their doctors? The choice is ours to make—or not to make—and as we take our next steps, we must be sure to open our eyes to the reality of our current health-care situation.

It is a modern-day American tragedy that, on any given day, more than 50,000 people will lose their insurance, even for a short period, and find themselves lacking coverage. It is an American tragedy that health-care spending per person has almost quadrupled since 1980, pricing millions of people out of the market.

It is an American tragedy that one-year-old children in America are less likely to have two shots of polio vaccine than one-year-old children in 88 other countries, including Mexico, Nepal and Uganda. It is an American tragedy that more than 60 percent of all children ages five to seventeen did not have dental insurance in 1989. And it is an American tragedy that our senior citizens—women and men who built our nation with their hands and their hearts and their minds—should now face the terrible choice of whether to buy prescription drugs or food.

So we're at a crossroads. One road leads downhill to continued hardship and failure. The other road leads uphill—although a steep climb—to a health-care system worthy of our citizens, our communities and our country.

You're at the outset of your careers, careers that should be meaningful and passionate. You dream of saving lives and building something great. So you know which road you have to take—and so do we.

Our vision is a health-care system that provides all Americans with the security of knowing that their basic health-care needs will be met. Security is what this whole health-care debate is ultimately all about.

Can working Americans get high-quality care when they need it most, regardless of whether they lose their jobs, move to a new state, or have to deal with a serious illness in their families?

Our mission—our mandate—is to provide that peace-of mind. And to do it, we need comprehensive change.

We need to build a health-care sys-

tem that contains our runaway health-care costs, while providing affordable coverage to all. We need to build a system that preserves the twin pillars of American health care: choice of doctor and continuing improvement in the quality of care. We need to build a system that recognizes the mouth as part of the body and addresses the tragedy that 150 million Americans lack basic dental benefits.

We need to build a system that encourages more young people to serve as primary care physicians, and that provides students with exciting new opportunities to finance their education through service. We need to build a system that emphasizes prevention, both by investing in broad public health programs, and by ensuring that individuals receive services, such as prenatal care, preschool immunizations, mammograms and check-ups.

We need to build a system that protects brilliant biomedical, behavioral and social science research as critical national investments in the crusade for a healthier America, and a healthier world. For it is research that will allow us to find cures and treatment strategies for Alzheimer's, AIDS and cancer, and for other deadly diseases that do not exist right now, in 1993.

Finally, and I can't say this loudly enough, we need a health-care system worthy of your dreams, your talents, your idealism and your pragmatism.

Let me tell you, the Clinton administration is aware of the particular concerns facing your generation of medical and dental school graduates: student loan repayment, the economic environment in which you will practice, the impact of health-care reform on your professions, and the costly malpractice insurance and the blizzard of paperwork that you may face.

Our reform package will address these concerns, rebuilding America's health-care system so that it provides security not only to patients, but also to doctors and dentists. That's our promise, because we want nothing more than for you to succeed in your careers.

I have great faith in your generation. I know your destiny is to make our world stronger and healthier and more humane. You are some of the most powerful women and men in the world for one simple reason: you have the power to help people every single day.

Ruth and Arthur Guyton '43 with their son Greg, their eighth child to graduate from HMS, and his wife, Michele. All 10 Guyton children are physicians.

Think of those whose lives you will enrich:

A 6-year-old AIDS patient in Virginia, living a longer and happier life because of the gains we have made against the disease; a 15-year-old in California who needs major reconstructive oral surgery after badly injuring his mouth in a hiking accident; a working mother in Montana who has put off regular mammograms and health screenings as she directs all her energy towards putting her children through school; a 73-year-old man in Boston who is suffering from Parkinson's disease and whose family is praying that we'll find a cure; and women, men and children in refugee camps all around the world who rely on the international health-care community to keep them alive until they are resettled.

Your patients will come from all regions and all ethnic and economic backgrounds. Whatever professional road you travel after Harvard, these people and thousands more will be there, depending on your minds and your hearts, your research, your judgment and your compassion.

Make no mistake, we want and we expect you to thrive in your careers. As we stand here at the crossroads and dream of a strong health-care future for America, we know we cannot get there without you.

You have all made an exceptional choice of profession, and your work is just beginning. That is because, like the universe itself, our body of health-related knowledge is ever-expanding, ever-evolving and filled with unexplored galaxies.

You will participate in extraordinary advancements in our quest to promote the health and well-being of all members of the global community—advancements that will push you to the limits of your abilities again and again, and require you to continue to learn for a lifetime. That's the intellectual and ethical mission you continue here today, and tomorrow.

I admire your commitment. I respect your desire to serve and to heal. And I have great confidence in your resolve to help build a better world.

Donna E. Shalala, PhD is secretary of the U.S. Department of Health and Human Services.

Coming to Consciousness

by Martin A. Samuels

I WAS GIVEN A GREAT DEAL OF ADVICE about this talk. People wrote me from every venue of my life; many even called me—solicited and unsolicited—from far and near. The best advice came from my daughter's math teacher, who was himself giving a talk at her graduation last week. "There are only two good kinds of graduation talks," he said. "Short and funny, and in your case, you had better stay away from funny."

Some of you may not know that I have spoken at Class Day twice before, in 1984 and again in 1988. In thinking about what I would say today, I reviewed the messages I tried to give your forbears. In 1984 I brought my dusty, unused clarinet here and spoke about the importance of maintaining a musical, nonverbal side to your life as physicians. I reminded the class that the brain had two sides: a verbal, rational, mathematical left hemisphere and a poetic, intuitive, spatially adept right. I emphasized the importance of the nonverbal brain in understanding and treating patients, and exhorted the students to keep these abilities facile throughout their careers.

(In fact, I took my own advice and began taking piano lessons myself about six or seven years ago. I can tell you that my moments struggling with Chopin and Schumann have been among the most satisfying experiences of my adult life and I think have helped me greatly in empathizing with my patients' problems.)

In 1988 I warned the class against the risks of hubris and excessive pom-

Grant Colfax and Sigurd Berven wait to join the procession.

posity; of taking oneself too seriously and forgetting the plight of the patient. I cautioned against the temptation to become too concerned with administrative issues, with cost effectiveness and the economies of health care, while losing sight of the interests of the patient, the real client in our business. I made a wish at that time that each member of the class be stricken by a serious but hopefully not lethal disease—an illness that would give them a brush with the medical system from the patient's perspective, so as to forever imbed within their own limbic systems the feelings of hopelessness, panic and loss of control felt by the patient.

I realized in looking back at these two talks that there was in fact a thread of continuity connecting them, leading me naturally to the message I want to give you today. Not surprisingly, it is a neurological thread, having to do with the acquisition of consciousness.

I realized that I had been struggling over the past decade to tell you and your predecessors something about the development of my own consciousness and its relationship to the way I see our profession now and in the future. I want to transmit to you why I have such a feeling of optimism about medicine, even in the face of all of the crepe that has been hung around us.

Doctors have become obsessed with the concept that something potentially lethal is happening to their profession. Doctors themselves are advising their children not to go into medicine. Numerous articles have appeared in the lay press over the past few months, characterizing doctors as being alienated by society and hostile toward the potential changes that are in the offing. Why in the face of all of this do I feel so optimistic about our future and what is there in the thread of messages that I have been giving you over the past 10 years to support this optimism?

I'm going to tell you a very personal story of the development of my own medical consciousness and how it was influenced by the era in which I came of age intellectually—the '60s. Consciousness is an illusive concept to define. As a neurologist I see it as a function of the brain with two major aspects, each with its own underlying anatomy. For the sake of the nonmedical people here, let me spend a moment to teach you all a little neurology.

The first aspect of consciousness is what we call arousal or wakefulness: the ability to wake up. An animal that is unable to wake is in a sense unconscious. The systems that subserve the normal rhythms of wakefulness and sleep are entirely contained within the brain stem, that lower and largely automatic part of the brain. This part of our nervous system has been conserved over eons of evolution, remaining much the same as it was in some of our most primitive ancestors.

The most obvious outward manifestation of this system is the function of the eyes. When the eyes are closed the animal is probably asleep; when open, it's probably awake.

Imagine yourself sitting in your living room, and someone looks at the dog on the hearth and exclaims, "Look, the dog's asleep." What neurological exam did that lay person perform in just an instant that allowed him or her to make such a rapid and, as it happens, accurate diagnosis? If the dog looks asleep, it is in fact very likely that the dog is asleep. If the eyes are open, the dog is probably awake; if closed, it's probably asleep. Simple, isn't it?

However, it is obvious to all of us that for human consciousness, arousal is necessary but not sufficient. It's clear that a person may be awake (meaning the eyes are open) and still be, in a sense, unconscious. This other aspect of consciousness is the feature that is possibly uniquely human or at least limited to our closest evolutionary relatives. This phenomenon, summarized with the rather inadequate word "awareness," is subserved by the huge cerebral hemispheres that have been engrafted upon the primitive brain stem, their massive enlargement marking the major difference between our brains and the brains of other animals.

When I was a high school student in the early 1960s, we were all particularly interested in the concept of consciousness. Let me give you a definition from that era and see who

among you are of the proper vintage to recall the author: "Consciousness is a being such that in its being its being is constantly in question in so far as that being implies a being other than itself."

This is the definition of consciousness from the essay *Being and Nothingness* written by John Paul Sartre in 1943. What does it mean? I recall our arguing its meaning into the depths of the night. It took me roughly 30 years to realize that this definition was complete gibberish. I was delighted to find out that my philosopher colleagues also found it virtually impossible to understand Sartre. When asked what he thought was the essence of consciousness, one of my philosopher friends told me it was clear that an animal was conscious if it had eyes that looked at you. When asked how he knew this, he replied, "It's intuitively obvious," a phrase I recall with some horror from philosophy class. That is, animals like dogs and cats, cows and pigs, horses and people obviously and intuitively possess consciousness, whereas ants and flies, crickets and mosquitoes probably don't. Put another way, an animal has consciousness if you would feel badly should you step on one.

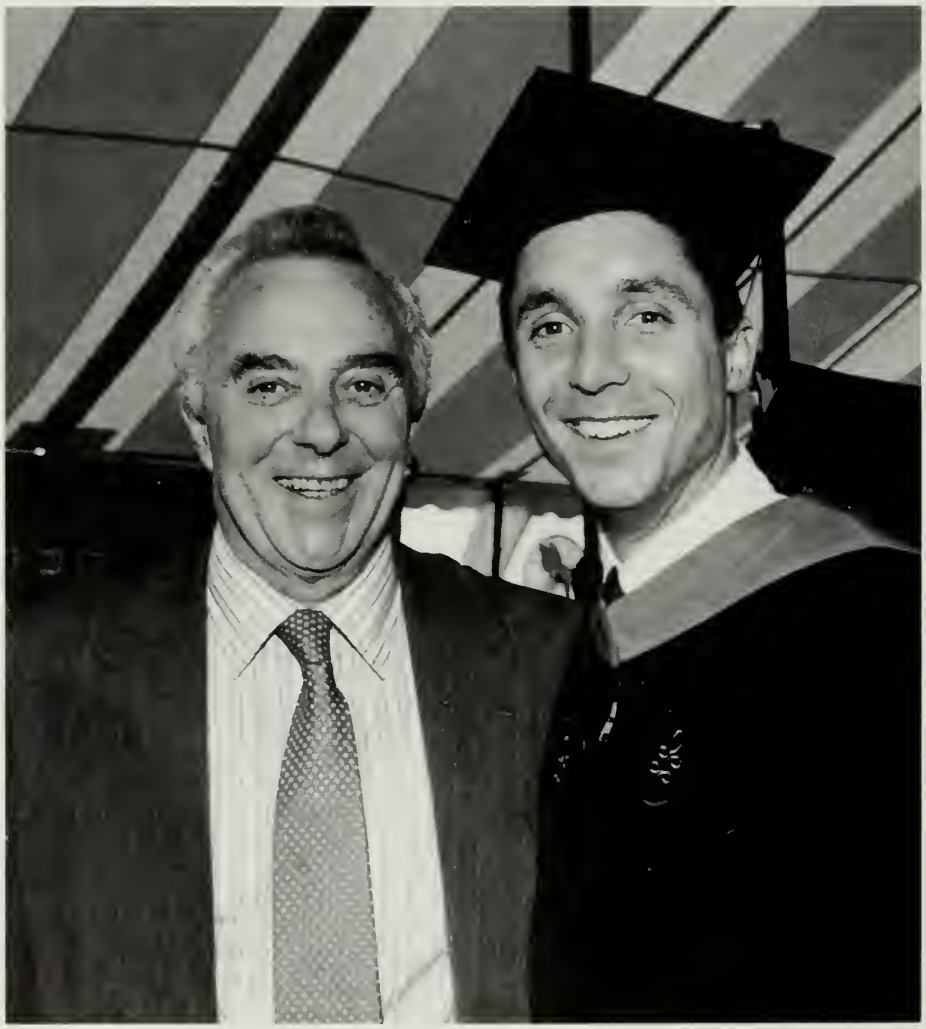
In pondering this definition, one cannot help but wonder about lobsters. You feel badly as you hold the lobster over the pot of boiling water—but you get over it. Perhaps consciousness is not an all-or-none phenomenon, but rather a continuum ranging from clear absence of consciouness (as in amobae) to clear consciousness (as in people). Lobsters are apparently somewhere in the middle.

It's clear that the first aspect of consciousness, namely arousal, is present from the time of birth and probably even before. It's easy to tell even in the youngest infant whether the person is awake or asleep simply by looking at the eyes. But when does one acquire this second aspect of consciousness summarized loosely as awareness. Because of the fact that our nervous systems are not fully developed at birth, it's likely that this second aspect of consciousness creeps up on us gradually as we age. Perhaps our first memories reflect the beginning of our awareness.

I was born in 1945 at the end of World War II and lived in a middle class suburb outside Cleveland, Ohio. To give you an idea of how long ago this was, just as I began to acquire my own consciousness, in 1948, the Indians actually won the World Series. This week I was reminiscing with my father, who tells me that I had memorized the names of all the players in the World Series pennant. Unfortunately, I can't remember this. The Indians as world champs just is not part of my consciousness.

By 1954, when the "Tribe" won the American League, but lost the World Series in four straight to the Giants, I have a clear memory of what life was like. I remember Willie Mays snagging that infamous long fly off the bat of Vic Wertz, over his left shoulder, heading toward dead center. I clearly recall my parents being afraid to let us go to public swimming pools in the summer for fear of the poliomyelitis epidemic. I recall taking the first Salk vaccine and then lining up outside my elementary school with everyone in the neighborhood to take what were called SOS (Sabin Oral Sundays), a sugar cube with the Sabin polio vaccine.

I remember the Cleveland Browns drafting Ernie Davis, the great fullback from Syracuse University alleged to be the next Jim Brown, and I remember going to Cleveland stadium one sum-



Joe Califano Sr. and Jr.

mer night in a pre-season game and watching him walk out onto the spotlit field after his diagnosis of leukemia had been announced. I remember having an intense sense of tragedy as I watched this young, apparently healthy man walk to the center of the field, knowing that he was destined to die of this incurable disease. I wondered what marked the difference between this lethal illness and the vague memory of infantile paralysis that my parents feared, but which was not really a part of my consciousness—the sugar cube had taken care of that.

In 1963 I went off to college in Williamstown, Massachusetts, an idyllic atmosphere where I could read and study and of course take road trips. I recall being awakened from a nap that first year by a close friend who told me that the president had been shot. That event more than anything else marked what I would call the beginning of the real '60s, followed by the continuing struggle over the war in Vietnam and the assassinations of Martin Luther King and Robert Kennedy.

But for my own personal consciousness, the seminal event occurred in 1967. I had taken the bus home for vacation as I sometimes did—a long ride from Williamstown to Cleveland. I was met by my parents at the bus station and as I got in the car, I looked at my mother and realized that she was ill. Her feet were bandaged and there was an anxious look on both my parents' faces. It is an image that is imbedded forever in my visual memory.

She told me that she had had a lump in the groin, a malignant lymph node. The bandages on her feet were the result of a test known as a lymph angiogram, a now outmoded method of evaluating the spread of lymphoma, from which she suffered. This is an illness that today is eminently treatable and often curable, but in those days was a virtual death sentence.

Despite some efforts at treatment, she rapidly declined during my first two years in medical school and in 1969 she died. During the two years of her illness, I was a medical student trying to study anatomy, physiology, biochemistry and pathology, just as you have done. This was also in the midst of the Vietnam War, disruptive times of anger and distrust engendered in my generation about the role of our government in what we considered an immoral conflict.

In 1968 the musical *Hair* appeared on Broadway, a manifestation of the disenfranchisement and anger of the generation of the '50s and '60s.

Student co-moderators Robert Vonderheide and Gretchen Fisher present class award to Edward Hundert.

Joan Lo and Mara Lockhardt listen to Class Day speakers.

Although a powerful landmark of the day, its message has not lasted. It is dated, tied inexorably to a war and a period we have tried to forget.

In 1969, at the end of my second year of medical school, the rock opera *Tommy* was created by Peter Townshend and The Who. Its story resonated with our era. (Two years later, my medical school class at the University of Cincinnati created a senior play, a rock opera, which melded elements of *Hair* with much of the music from *Tommy*, to which we put our own words. This rock opera, which we entitled "Hirsutism," produced for us an incredible bonding experience, which allowed us to break out of the '60s into the new era.)

The story of Townshend's opera is about Tommy Walker, whose father Captain Walker was lost in the war prior to Tommy's birth. But Walker was not dead. He returned to find his wife in bed with her lover. There is a struggle, ending in a murder, observed by Tommy as a young child.

The surviving couple realize that the child had seen the entire event and they excoriate him. "You didn't hear it, you didn't see it, you won't say nothin' to no one ever in your life. You never heard it. Oh how absurd it all seems without any proof. You didn't hear it, you didn't see it, you never heard it, not a word of it. You won't say nothin' to no one. Never tell a sole what you know is the truth."

We were Tommy about to enter the '70s, about to leave medical school and go out into what we called "the real world," and we were told that everything that had happened to us in the '60s was to be ignored. We didn't see it, we didn't hear it, we didn't feel it. It didn't exist.

As a result of this trauma, Tommy developed what we would now call a conversion symptom. He becomes deaf, dumb and blind. All efforts to cure him failed, including the use of psychedelic drugs by the acid queen. But Tommy had a chance. There is a possible cure and the doctor is called.

Listen to the remarkable neurological exam done by Peter Townshend's doctor: "He seems to be completely unreceptive: the tests I gave him show no sense at all. His eyes react to light, the dials detect it; he hears, but cannot answer to your call; there is no chance, no untried operation; all hope lies with him and none with me. Imagine though the shock from isolation when he suddenly can hear and speak and see. His eyes can hear, his ears can see, his lips speak, all the times the needles flick and rock. No machine can give the kind of stimulation needed to remove his inner block."

A mirror is held up to Tommy. In it he sees the reflection of the damaged child. The cure is for him to break through the mirror. Tommy stops looking into himself, stops obsessing about himself, stops feeling sorry for himself, ends the narcissism, breaks the mirror and is cured.

On June 13, 1971, I graduated from medical school and, at a ceremony much like this one, I was asked by my class to speak on its behalf. The talk was entitled "Mark Hopkins on One End and I on the Other," an allusion to a quotation by President James A. Garfield, made 100 years before in 1871. He was commenting on the essence of the true teacher and referred to the renowned professor and then president of his (and my) alma mater, Williams College. He said, "I am not willing that this discussion should close without mention of the value of a true teacher. Give me a log hut, with only a simple bench, Mark Hopkins on one end and I on the other, and you may have all the buildings, apparatus and libraries without him."

On behalf of my class, a product of the world I just described to you, I asked that the medical school change its priorities from a search for high technology to an emphasis on small group and even individual education: in other words the New Pathway, a process so courageously championed by Dean Tosteson here.

I am sure that I and others of my disposition, teacher-clinicians, could not succeed anywhere else in the United States as we have succeeded here. This reconfirmation of the teacher-clinician as a vital part of the medical school has afforded me the environment in which I can create a department aimed at both treating the

patients of today and seeking the advances needed to conquer the plagues of our era, while teaching both arts to the doctors of tomorrow. You may take it for granted, but nowhere else could a person of my ilk both direct a service at a major hospital like the Brigham and maintain a major priority for teaching and patient-centered clinical work. The fact that you can sit in a small room with Ed Furshpan at one end and you at the other is an extraordinary testament to the radical revision our school has undergone.

Your generation acquired consciousness in the '70s and '80s, as I did mine in the '50s and '60s, but the problem of the mirror remains. All of the doom and gloom that we hear about the future of medicine in this country is a manifestation of our obsession with ourselves. What will the change in medical care do to us? What will it do to our lifestyles? What will it do to our income?

What I think you need to do is break the glass, stop looking at yourself in the mirror, and get on the other side into the patient's skin. The message that I have been trying to give you for the past decade in various ways is this message of *Tommy*. Think of the patient. Imagine yourself as the patient. Use your right hemisphere to feel what the patient feels.

All of the important questions that we need to address as doctors are posed by our patients if only we put ourselves in their places. One brush with illness will teach you this in a vivid and personalized fashion. Our main job is to be the patient's advocate, give the patient the best we can, and try to find treatments and cures for the diseases of today that are analogous to the lymphoma and leukemias and polios of my era.

The challenges for your generation are obvious: AIDS, Alzheimer's disease, pancreatic cancer, brain tumors, Parkinson's disease, ALS (Lou Gehrig's disease). Many of these illnesses will be defeated in ways analogous to the polios and lymphomas of my time. In the interim, let's break through the glass and get into the patient's skin.

Don't forget, consciousness is in the eyes. Open your eyes. Touch the patient and feel what the patient is feeling. Let the patient tell you verbally and nonverbally. Let him tell your left hemisphere with his words, and your right hemisphere with his feelings what he or she needs. Let that guide you in your career. If we do this as a profession, I predict that changes in the delivery of health care will occur in a completely atraumatic fashion.

Listen to the final words of the rock opera Tommy. It's the patient talking to us: "See me, feel me, touch me, heal me. See me, feel me, touch me, heal me."

And then it's us talking to the patient: "Listening to you, I get the music; gazing at you, I get the heat; following you, I climb the mountain, I get excitement at your feet. Right behind you, I see the millions; on you, I see the glory; from you, I get opinions; from you, I get the story."

Martin A. Samuels, MD is HMS professor of neurology, chief of neurology at Brigham and Women's Hospital, and director of the Harvard-Longwood Neurology Teaching Program.

Dean Tosteson congratulates Christopher Wright.

The Art of Being There

by Stefan G. Kertesz

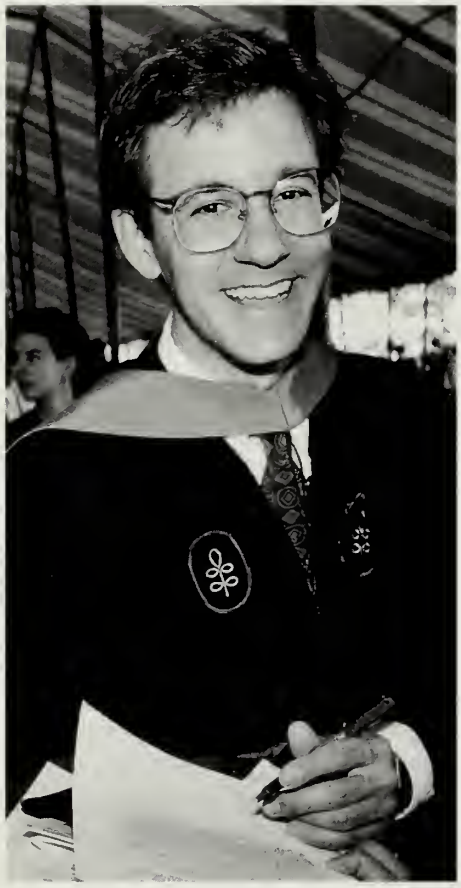


photo by Barbara Steiner

"Who are we fooling at graduation? It's clearly not over."

I was eating pizza the other day with a friend, a member of this graduating class, and he asked me that question.

He's got a point. It's really not over. Think about today. Here we sit while Mom and Dad proclaim our victory (and their victory) and each of us knows full well that within two weeks, we'll be back on the wards, little more than rank novices in a system we can't even pretend to have mastered.

So on June 10, what can we honestly celebrate? What are we marking? What's the point?

In my first attempt to answer this question, I considered a more specific issue: What skills can we say we all actually developed here at Harvard? After all, one might assume that every medical school graduate is master of a well-defined set of knowledge and skills. Last December my father pulled me aside and asked, "Now Stefan, I know you're not going to be a surgeon, but do you feel like you would be ready to remove someone's appendix if you had to do it?"

I responded with words to the effect of, "No, but I would know where to look up that information if I had to." Of course, I think I could have located Countway Library before I went to medical school, but four years and $120,000 later, some very important changes have taken place. For one, I have borrowing privileges.

Out of respect for my father's eminently practical concerns, however, let's stick to nuts and bolts for a moment longer. What procedures have we all performed? Chest tubes? Lumbar punctures? Arterial lines? No, one cannot say that all of us have learned to do any one of these tasks. Perhaps there can be no truly viable set of procedural objectives for the medical school experience. But if we don't have such a list, what can we really say at the end of our four years here that will spell out the meaning of this graduation?

This is my answer: We were there.

Is it anticlimactic, to say it that way: "we were there"? Sometimes here at Harvard, where new discoveries are broadcast daily, I think it's easier to be a hero and save the day, start that CPR, clone that gene, take out that appendix—easier because everyone notices these things, pats you on the back and says "strong work."

What most of us did, most of the time, was harder than that. What we did was show up and give our best effort, even when no one noticed, and frankly it didn't change the course of anything. we showed up to dissection the first day to meet our cadavers, and then the next day we came back. In the first week of Introduction to Clinical Medicine we were taught to listen to the lungs, and the next week we came back, even when we knew we weren't hearing what one is supposed to hear. On the wards we were eager, even when we couldn't possibly have understood what we were supposed to be eager about. We tried to look interested and do a good job, even when we knew the other student was more interested and doing a better job.

And while the system only gave us this small role, we took what we were given and difficult as it was, we tried to make it work. And only rarely did people pat us on the back for being there, for taking the position of student, and putting in our effort.

A few residents might have said, "strong work," but for each one of us who got that pat on the back, that honors grade, there is another who worked just as hard and got no kudos. And in the administration building for such a person, there sits an evaluation that says, "Sarah or Sean or Savitri or Stefan has completed the rotation here at Hospital X and has always showed up for rounds, and we're sure will make a competent physician. Grade: satisfactory."

Being there was not easy. But being there and being willing to offer what

one can, counts. If people only worked when they could be heroes, when they were sure they would get honors, when they were sure they would be published in *New England Journal* or *Nature*, then there would be a lot of people in this tent who spent the last four years sitting on their rear ends, and that's not the case.

Most of the time, most of us did not get to be heroes. But we were there. Moreover, most of the patients waiting for us out there, waiting for us to do their delivery, their vaccination, their tonsillectomy, their blood pressure check, or even to do their bypass—most of them are waiting for us not to be heroes, but first and foremost to be there—with them, and with our knowledge.

The fact is that in the years here at Harvard Medical School we've proven that we can be there. And I say that "being there" is the first duty of a doctor, the first duty of any person who chooses to put him- or herself alongside the human being who is suffering. Presence is the first nine-tenths of healing. Of course it does help to have a scalpel if one is planning to operate. But as long as we're talking about the tool kit, we can recall that presence was the first thing we ever pulled out of the doctor's bag. We were there.

Perhaps at this point, as I draw these remarks to their close, I should recall that it was not just we who were there. I remember one night on my medicine rotation. I sat down in the house-staff library to begin writing up my patient admission at the beloved hour of 1:00 AM. Unlike the Samoans when Dan Quayle last paid them a visit, I was not a happy camper. My traditional late-night support system—cookies and coffee—offered none of its customary solace. I sat down. I stood up. I went to the phone. I took advantage of the three-hour time difference to the West Coast to do a little follow-up chat with my family. In the comforting words that crept back over the line, I found the strength to return to the house-staff library and write.

Few if any of us were ever there all by ourselves. In fact, most of us could not have been there had not others, in turn, been there for us. All of us under this tent today have had real practice in the art of being there.

We can say of these years, with absolute certainty and with pride, "We were there, and what we did counts." And we can say for ourselves next year, "We will be there, and what we will do will count."

Stefan G. Kertesz '93 is doing a residency in medicine at Beth Israel Hospital, Boston.

Students Forever

by Sanjoy Dutta

ONE YEAR AGO, FROM THIS VERY lawn, the late Arthur Ashe gave future physicians a warning: "Whether you like it or not, the world is looking to you for answers." As our first day of internship approaches, the responsibility of providing answers has intensified. Quite honestly, some of us are a little scared. Have we really learned enough?

Now, parents, I do not wish to make you uneasy. Remortgaging your houses and selling your few remaining children into slavery in order to pay our tuitions have not been fruitless gestures; we have learned something. I remember one student who, upon witnessing his first delivery of a child, became light-headed and sat down right next to the father. Yet another student walked into her first day of pediatrics with an eager smile, a brand new suit, and her stethoscope on backwards, only to receive an unexpected greeting from an undiapered six-month-old.

We have made some progress since then. We have learned the workings of the human body, often from the level of a disease's social impact down to its molecular basis with, of course, the many unknowns in between. In our first months, we would answer questions with, "I don't know." We have learned from the experts, and we now answer, "We don't know."

Imagine, like the movie *Alive*, that you were all the survivors of a plane crash in the Andes. Instead of a soccer team to help you survive the freezing mountains, imagine that you were accompanied by the 1993 graduating class of Harvard Medical School. "Wonderful, wonderful," you would think, "what a wealth of useful information."

Well, think again, because I really do not know how to treat frostbite and would be the first to suffer from it. If circumstances were to require cannibalism, I would be asked, "What is the most edible part of a human body?" After close consultation with my colleagues, we would reply, "We do not know the answer to this. In some parts of the world, we see this, but there is always a risk of contracting a rare neurological illness called kuru. I am

sorry, but perhaps a nutrition consult may be helpful."

We cannot hope to have answers to every improbable and esoteric medical question, lest the stress drive us to prescribe more Maalox for ourselves than for our patients. Fortunately, this is acceptable. When Sidney Burwell retired as the dean of Harvard Medical School over 40 years ago, he told students that half of what they had been taught was wrong, but that, unfortunately, he could not tell them which half it was.

Thus, some of us find relief in shifting attention away from books and theories and onto people and stories. All of us have held the hands of couples delivering their first child, of patients with lives unraveled by psychoses and depression, of the elderly who continue to live full lives, and of some younger than us who have been denied the chance to go on. In return for the answers we provided regarding their diseases, their struggles disclosed to us the subtle answers of living.

I am reminded of a patient who was close to her death when I first met her. Nevertheless, I read about her illness in books and journals and educated myself on risk factors and vague theories of pathogenesis, motivated by the naive notion that a little extra knowledge can save anyone. When I walked into her room, she did not ask questions about her disease or the results of her latest test. She asked for advice on how to best live her last days. I was not very helpful. I was less prepared for my ignorance than she was for her death, and being a physician herself, she understood my frustration and consoled me. "There's an old joke," she said, "that the difference between God and a doctor is that God does not think he is a doctor."

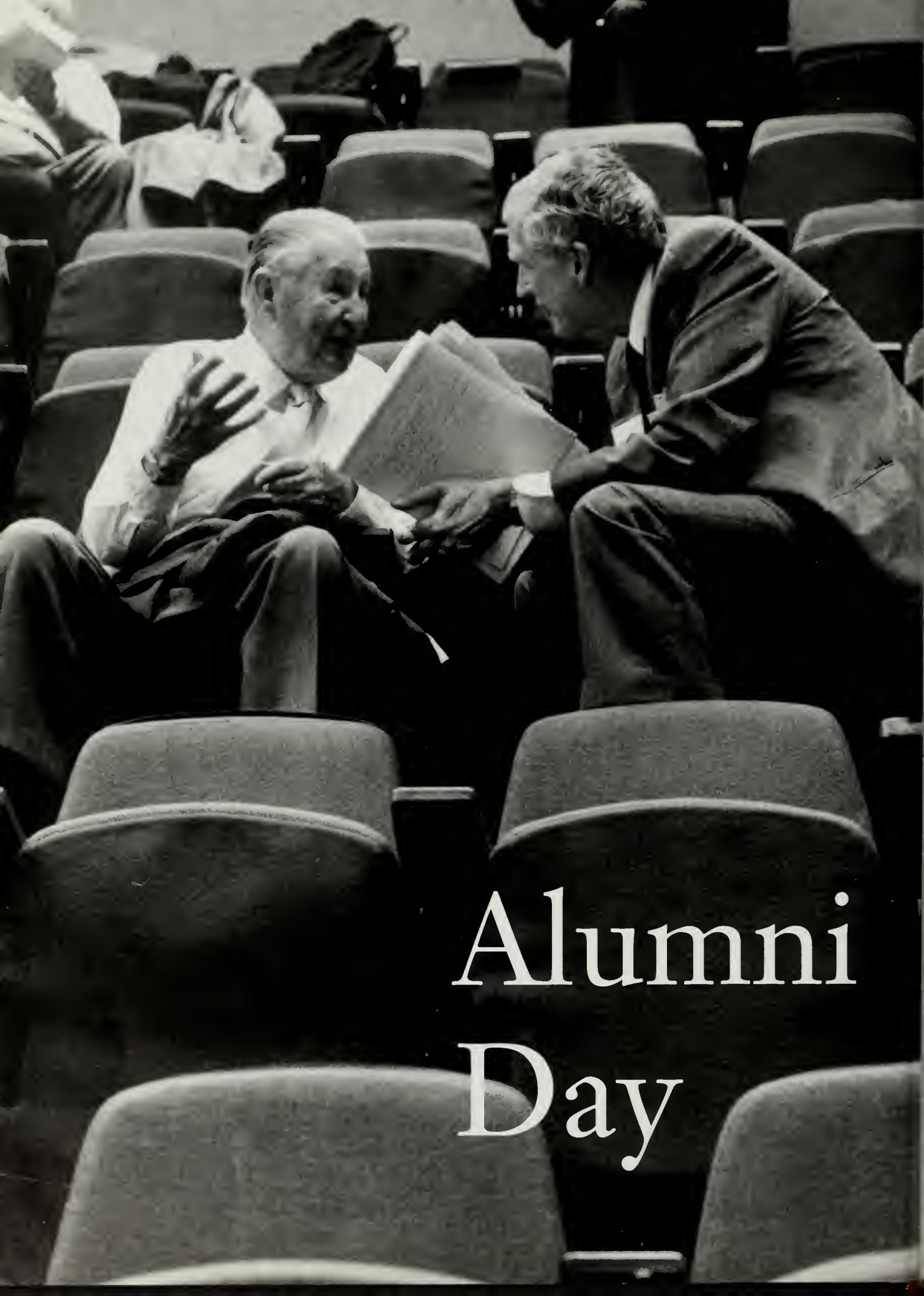
She reminded me that some day I too may be a patient. I try to remember this every time I chide a heart attack survivor about their atrocious diet, yet become excited myself when I hear McDonald's is having a two-for-one Big Mac special. Her story and her words remind me to define my roles and embrace my limitations.

Dean Martin and his mother.

As students forever, our curiosities and insecurities drive us in our search for answers. As doctors, we navigate our finite knowledge through the minefield of black boxes that carpet the field of medicine, hoping to also foresee the political and social forces that will weather the terrain in the days to come. And as human beings, we spend time with loved ones and hope to set aside a few moments now and then to listen to the wisdom of older women and men, before we become old ourselves. I am confident that each of us will play our chosen roles well, and in doing so will attain our common goal: to gently tip the balance in favor of a few human lives for some long moments on earth's time line.

In closing, I will with difficulty try to condense these past years into a few sentences. When we first arrived here, we expected to pursue the field of medicine, but quickly, in an almost shotgun fashion, we became married to it. Medical school has been much like the honeymoon. We entered our commitment unsure, eager and nervous. Through the night, we did not always know what we were doing and definitely did not get to do everything we thought we would. Our emotions ranged from frustration and embarrassment to hope, excitement, and wonder. In this marriage to the profession of doctoring, if indeed these past years have felt like a honeymoon, may the feeling never end.

Sanjoy Dutta '93 is doing a general surgery residency at the University of California, San Francisco.



Alumni Day

Responsibility of a Medical School to Society

THE DAY WAS A TEMPLATE FOR reunion: gorgeous, sunny and full of warmth and fellowship. It was the perfect setting for the rite of return back to the folds of the Harvard medical family.

The day began with the annual business meeting as alumni and spouses trickled into the tent, gradually filling it to capacity with the largest turnout ever. William V. McDermott Jr. '42 welcomed everyone and announced his retirement as director of alumni relations, a role Daniel D. Federman '53, dean for medical education, has assumed [see story on page 8].

Doris R. Bennett '49, chair of the alumni fund, reported that $1,224,141 had been raised from 54 percent of alumni during the annual appeal, and vowed to increase giving this year "to support all the wonderful programs you've heard about and to reduce the debt of our students."

This being the reunion year for the double class of 1943A and B, two class agents stood to present 50th reunion gifts—James Jackson '43A and Joseph E. Murray '43B—respectively with checks for $183,640 (85 percent participation) and $82,195 (81 percent). Jackson joked about how the two classes have remained good friends through the years, despite competition on the softball field, and said, "Most of us feel that ours is the most important class to which we have ever belonged!"

Jackson acknowledged, however, that no one in his class yet had won a Nobel Prize, and turned to Murray, offering him both the admiration of his class and the microphone. Murray began with characteristic modesty by saying, "Every class is the best and has its own heroes, sung and unsung." He said that he had done some research on the many notable people in each class, however, which he summarized by saying "Without a doubt, HMS is doing something right."

David Oakes '68 presented the 25th reunion gift of $83,366, representing 57 percent of his class, and remarked that the percentage of participation in reunion giving seems to go up in older classes. "I wonder if this means that donors live longer." Oakes also cited additional donations the Class of 1968 is making to HMS: Stephanie Pinkus as president-elect and two members of the incoming Class of 1997.

Outgoing president of the Alumni Association William D. Cochran '52 turned the gavel over to Robert J. Glaser '43B and it was time to let the program begin.

This year's Alumni Day symposium, moderated by Dan Federman, was on "The Responsibility of a Medical School to Society." In this climate of federal health-care planning, said Federman, "There is a very strong feeling, specifically in terms of practitioner specialization, about what medical schools owe society."

Robert Glaser '43B, trustee and director of medical science at the Lucille P. Markey Charitable Trust, approached the topic from his unique vantage as head of two foundations (his previous tenure was at the Kaiser Foundation) and former dean of two medical schools (Stanford and the University of Colorado), one private and one public. Glaser traced the role of medical schools in society from the release of Flexner's study in 1904 to today, citing such major factors of influence as the post-WWII surge in federal research funding and the social upheaval in the 1960s. To exert leadership in the new century, medical graduates must "keep firmly in mind the social needs that inevitably impinge on medicine."

For the patient's perspective, Federman then introduced a woman who needs no introduction, "who enters our homes every day, making house calls"—Ann Landers, the pen name for Eppie Lederer. As an example of her clout, Federman cited a column in which she advised that people fill out a living will, a sample of which they could get from Harvard Medical School. "We received over 60,000 inquiries and had to set up a special

office to handle the requests," said Federman.

The answer to the question, What do patients want from their doctors?, is very simple, began Lederer. "They want competence, compassion, and last, but not least, time." However great the miracles of modern medicine, "they cannot take the place of the old-fashioned family doctor who took the time to explain things."

The program then turned to discussion and questions from the audience, a "New Pathway style format," as Federman termed it, which has been enjoyed on Alumni Day the past three years. The first question came from a psychiatrist who noted that he detected a tone of ambivalence toward psychiatry in Ann Landers's column. She confessed that her enthusiasm for psychiatry has waned and that she is now more prone to tell someone to get counseling, and not to specify psychiatrists unless medication is required. (Psychiatrist Robert Vaughan '43B took to the microphone later and asked Landers if she were willing to be brought up to date through literature to get rid of some of the stereotypes—which she said she'd be glad to do.)

There was discussion about house calls and a question directed to what role, if any, a medical school curriculum should have in inculcating values that would help mitigate social ailments. Michael Stulbarg '68 admitted that "we as teachers are not serving as role models to students on how to be in touch with patients" and asked if the New Pathway is really addressing this. That part of the New Pathway is an unequivocal success, said Federman through the Patient/Doctor course, though he said they were less successful in the hospital setting where "the paperwork, the volume of patients to be seen, the speed and complexity of care, make it hard to demonstrate doctoring as much as before."

Reid Pitts Jr. '67, who was here accompanying his father, Class of 1933, drew a lot of applause in saying the medical school could be stronger, not in the curriculum, but in public pronouncements in the debate over managed care—"which has nothing to do with care, but rather with finance, with ambulatory and same-day surgery, with procedural medicine and with controlling access to the quality of care"—and making clear what it is doing to the doctor/patient relationship.

After a break in the Faculty Room and much continued discussion, the program resumed with Michael A. LaCombe '68, a country doctor in Maine, introduced by Federman as "one of the happiest internists I know." Using an incident from his first day at medical school, LaCombe painted the picture of a society that wants more primary care physicians but doesn't know how to go about getting them. Mentors are important, he conveyed, particularly ones who can tell students that they really can do anything they want to do in medicine.

For an inside view on what the government's health-care task force is up to, the panel turned to Atul A. Gawande '94, who is on leave from HMS to serve as senior advisor to the assistant secretary for planning and evaluation in the Department of Health and Human Services. He said that the public respects the country's medical schools, but wants more for their tax dollars—more of the kind of physicians they need, where they need them. "Unless we reform medicine to provide universal coverage for primary and preventive care, and not just acute care, and unless we reward primary care physicians with autonomy, assured coverage for their services, and the guiding role in their patients' care, reforms in medical training will have only modest effects. We students will

Ann Landers talks with Joseph Murray and his wife, Bobby (right).

continue our surge into specialties. We will stay on the coasts where we are trained. The public and politicians will grow more frustrated with the public investment in medical schools."

Discussion again turned to the audience, who strayed from questions about alumni giving to who teaches the teachers. Gawande was asked about the perceived lack of physician input and leadership on the task force, to which he responded that many alumni are very actively involved. He pointed out that HMS faculty member Arnold Epstein is in fact one of the leaders who has convened a group of 60 physician-reviewers from around the country—active, practicing physicians, not just academics—to review malpractice reform, cost containment and universal coverage as well as ways of reducing the administrative burden physicians are now under.

Diverging points of view were expressed regarding the role of HMS in producing primary care practitioners. Phil Goldsmith '67, himself an HMS/Brigham primary care practitioner, said that it would subvert the purpose of an institution like HMS to consciously try to guide people into primary care when what makes it different is that it is a trainer of the teachers and the leaders of medicine in the United States and the world. "A few apples always roll away from the tree, and therefore we'll always have some Harvard-trained primary physicians around, but fundamentally we are not here to train primary care physicians."

Ellen Weber '83 countered by saying that "exactly because schools like Harvard and Hopkins are leaders in medical education, if we want our society to have more primary care physicians and value that, then these are the schools to produce such practitioners."

With great reluctance, Federman stopped the discussion and, wrapped it up by saying, "A good education should raise more questions than it answers."

Before breaking for lunch, Dean Daniel Tosteson '48 updated everyone on developments at the school. He spoke of new department heads, renovations, and of Harvard University President Neil Rudenstine's efforts to bring the whole university community closer together. And it is on that chord of connectivity that he ended, saying to reunioning alumni: "You are wonderful to come back and revisit us and restore your connections with this institution."

What Patients Want

by Ann Landers

WHAT DO PATIENTS WANT FROM their doctors? I can tell you in one sentence—they want competence, compassion, and last, but not least, time.

First, competence. Every person who goes to a doctor wants to be sure that that doctor knows what he or she is doing. Well, how do you find such a doctor? If you're new in town and not sophisticated enough to know about physician referral services, and most people aren't, you ask a friend or a neighbor, or someone you work with, to recommend a really good doctor.

The office manager tells you that Dr. Smythe is just wonderful—when the results of her tests came in, he sat with her and explained everything in language she could understand. He ruled out all the frightening things she thought she had—first, of course, cancer—which is the most terrifying word in the English language, and then he explained how stress can make your heart beat so fast you're afraid you are having a heart attack, and how worrying can make you sick.

She says that after Dr. Smythe talks to you for a few minutes, you are convinced that he is the smartest doctor in the entire world because he explains things in language you can understand.

So, you go to Dr. Smythe, based on a glowing recommendation and your attitude is very positive—which is a wonderful way to start a patient/doctor relationship.

Patients want their doctor to take them seriously. They know he's busy, but they have a desperate need to talk. And they want a doctor who will let them talk, and who will talk to them.

Time is precious, doctors are busy. They are over-booked and always running late—burdened with tons of paper work, emergency phone calls and patients who just checked into the hospital and have to be seen. But when Mrs. Jones comes in, she wants you to spend some time with her—and time is exactly what you don't have a lot of. So, you do your best to be patient and attentive, to allay her fears, and without coming across as unsympathetic or judgmental, you tell her she really should stop smoking, and her back wouldn't hurt so much if she lost 30 pounds, and she should do those exercises you demonstrated when she was in the office three months ago.

If I were on the faculty of a medical school, I would make sure that every student was given a class on how to conduct a physical examination. Several years ago during World War II, which is probably before some of

HMS '43 at Camp Barkeley, Texas, February 1944. *Front row, l-r:* Charles A. Kane, H. Waldo Bird, William C. Flinn, Rafe Banks, Dante Campagna-Pinto. *Back row, l-r:* Allan L. Friedlich, Henry F. Allen, Logan O. Jones, Richard A. Betts, Ernest Craige, Harold Brown.

The Great Divide

"How it is that there are two classes in one year?" asked James Jackson '43B on Alumni Day. "I'm going to explain it, even to those who don't care very much."

Jackson then provided a brief explanation as to why the Class of 1943 is seemingly split into two halves. During WWII classes were accelerated, with graduations in March and December. "The two classes have remained good friends ever since, with a little competition in softball games at reunions."

While quick and to the point, Jackson's description doesn't get to the heart of the question: Why, (and how)

you were born, I went to a gynecologist at La Garde General Hospital in New Orleans for a routine annual examination. I was younger then, a bit more timid, and I hadn't yet received my diploma from the Reader's Digest School of Medicine.

Dr. Hanson poked, prodded, adjusted the lamp, poked some more and then he cleared his throat. "What did you say?" I asked.

He replied. "I didn't say anything."

Another few moments passed. More poking. And more silence. Finally, after what seemed like a very long time, I said, "Do I have some kind of problem, doctor?"

"Oh no," he said. "Everything looks good. In fact, you're in excellent condition."

I was greatly relieved, but annoyed that he had kept me waiting for what seemed like an eternity before he let me know I was in excellent condition.

Silence can be frightening, especially during an examination. Just a few words of reassurance can mean so much to a patient who is scared to death that something might be wrong. Some doctors don't know what it is like to be a patient. I believe that once a doctor has been a patient, he or she becomes a better doctor.

If the physician feels a lump, he or she should immediately say something reassuring, such as, "I feel a little thickening here, but so far as I can tell it's nothing serious. We'll look into it just to make sure." If further tests indicate a malignancy, the doctor should relay this information in a calm and supportive manner. No matter how bad it looks, the patient must never be left without hope. The doctor's ability to reassure a patient can help activate the body's healing system. Positive emotions are biochemical realities.

For many years I have been a firm believer in the body-mind connection. We now read a lot about the mind's power to heal. I would go a step further and talk about the mind's power to keep from getting sick—because it has worked for me.

In the old days, before sexual harassment became the lawsuit of choice, a male doctor could hold a female patient's hand when he spoke to her about her illness. Or he could put his arm around her shoulder to soften some bad news. But those days are a thing of the past. America is the most litigious country in the world. We have become law suit happy and, of course, the patient has to pay for the doctor's malpractice insurance.

I know something about patient/doctor relationships because people have been writing to me about this subject for over 35 years. My readers tell me everything—sometimes more than I want to know.

I receive approximately 2,000 pieces of mail every day. Obviously, I cannot possibly read every one of those letters but I do read a great many of them. So it is fair to say that I have a direct pipeline to the hearts and heads of the American people. I know what they think about every conceivable subject—because they tell me.

Would you like to know the most frequent complaint I get from my readers about doctors? Well, it's the

exactly, is there an A and a B for the Class of '43?

The answer is found in an announcement published by the medical school in 1943. The call came out; Uncle Sam needed doctors and he needed them fast to aid the war effort. In response, HMS initiated an "accelerated" program in July 1942, seven months after Pearl Harbor. The incoming class entered in July '42 instead of September and the upperclassmen followed suit, resuming their study after only one month of summer vacation. All classes lost the long holiday break. The fourth-year class, Class of '43, graduated in March 1943, and became the As. The original Class of '44, also accelerated, then graduated in December '43 and henceforth were known as the Bs.

"They've been called A and B as long as anyone can remember," says Richard Wolfe, curator of Rare Books at Countway Library and HMS historian.

When asked how he felt about losing his summer vacation, Ben Eiseman 'A said that it was "small potatoes compared to what other people from other walks of life were giving up." Joseph Murray 'B concurs: "We were delighted to be in medical school and be allowed to continue. Other people who went to college were sent overseas."

The acceleration was necessary, because "The needs of the Army and Navy are for well-trained physicians. No sacrifice of the time required for teaching is possible if thorough training is to be maintained," says the medical school announcement. The school insisted that the same number of academic days be fulfilled for each year, so the students' leisure time was sacrificed but not their education.

"The School believes its prime responsibility is to train physicians for the armed forces," said the announcement, and in fact, 90 percent of the student body were commissoned and scores of faculty and teaching staff entered the war effort. HMS, MGH and BCH composed the 5th, 6th, 7th and 105th General Hospitals, three of which were on active duty. "Almost without exception, people were eager to serve," says Allan L. Friedlich 'A.

"There was quite a different living style in Vanderbilt Hall, however," says Murray. "The army guys were all privates, and the navy group were all officers, and we were all in the same class." He says the difference in classification wasn't taken so seriously that classmates attempted to outrank each other, but was all treated with good humor.

Since graduation and the end of the war, the As and the Bs have always been close, says Friedlich and reunioning together "tended to add to the closeness and friendly competition" between the two.

And that's the A, B and C of it.

Terri L. Rutter

feeling that they are not getting enough of their doctor's time. This letter says it fairly well:

"Dear Ann Landers: My husband recently had a stress test. We were referred to a cardiologist by our family physician. The cardiologist was not only 45 minutes late, but all he did was pop into the test room three times to ask my husband, 'Are you OK?' He barely waited for a response before he was gone again. By the time my husband was disconnected from the EKG and dressed, the doctor had left the hospital and was unreachable. My husband had several unanswered questions and was completely frustrated."

The woman continued, "It is a shame that patients must put up with doctors who think they are gods. We are treated as though our time doesn't mean anything. This is why so many of us are turned off on the medical profession." The woman signed her letter, "Fed up in New Orleans."

I replied, "Dear Fed: The medical profession has changed dramatically these last 20 years, and it's not completely the doctors' fault. Today's doctors are socked in by tons of paperwork and insurance forms and plagued with the threat of malpractice suits. This is why they give every test known to mankind. They need to cover themselves in case they get sued.

"Some doctors are arrogant, but so are some lawyers and architects. Many doctors are still compassionate and caring, and, as for that cardiologist who did your husband's stress test, he sounds as if he is overworked and stressed out himself. Practicing medicine today is not exactly a day at the beach. I admire the young men and women who are brave enough to enter this field, given the challenges they are faced with."

I received hundreds of letters from doctors thanking me for that response. Medicine has changed a great deal in these last three decades. The explosion in the field of medical technology has been spectacular and it has saved countless lives, but this high-tech equipment has also deprived the patient of the human touch. Patients are seeing a lot less of their doctors these days and a great deal more of the technicians who operate the CT-scans, the MRIs and the mammography hardware.

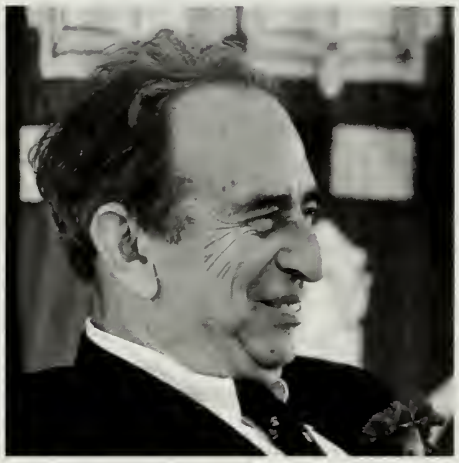
The miracles of modern medicine are mind-boggling, but they cannot take the place of the old-fashioned family doctor who took the time to explain things and made their patients feel that they were more than "prostate 88 in room 192."

Is this the price we must pay for progress? Let us hope not, because it would be a very bad bargain indeed.

Ann Landers (Eppie Lederer), the most widely syndicated columnist in the world, is based at the Chicago Tribune. She has written seven columns a week since 1955.

A Socially Aware Curriculum

by Robert J. Glaser



THE TITLE OF THIS SYMPOSIUM, "THE Responsibility of a Medical School to Society," brings to mind the 1955 presidential address delivered by the late Vernon Lippard, dean of Yale Medical School, at the annual meeting of the Association of American Medical Colleges. He described the medical school as the Janus of the university, referring to the fact that the mythical figure had two faces looking in opposite directions. Dr. Lippard pointed out that unlike almost all other components of the university, the medical school has two roles: one in the university and the other in the outside community. The latter, of course, relates primarily to the clinical activities of the university's teaching hospitals, which have expanded substantially over the past 50 years.

I have been asked to focus particularly on social needs and medical school curricula. I would like to introduce into this discussion some historical perspective as a backdrop to the enormously rapid and substantial changes that have occurred and are continuing to occur in medicine, referring first to Abraham Flexner's famous study, *Medical Education in the United States and Canada*, published in 1904 by the Carnegie Foundation for the Advancement of Teaching.

The influence of this report in upgrading the quality of American medical education in the early part of the century was profound. Flexner devoted much attention to the components of proper education for physicians. He emphasized the need for medical schools to encompass science as an important part of the study of medicine and pointed out the essentiality of a meaningful clinical experience for medical students rather than the passive participation so characteristic of that period. Yet, if one reviews Flexner's monograph, one finds little evidence of concern on his part for the social needs of society other than the obvious implication that better educated doctors would serve the sick and suffering more effectively.

Some 30 years after the publication of the Flexner report, when those of us now celebrating our 50th reunion began the study of medicine in these precincts, the curriculum adhered closely to the Flexner principles. It incorporated the science of the time, both in the preclinical courses as well as in the clinical clerkships, albeit by today's standards what was known about many diseases was relatively limited. For example, there was minimal reference to the genetic basis of disease. This is not surprising, inasmuch as it was not until the year after we graduated that Avery, MacLeod and McCarty published their landmark paper demonstrating that DNA was the chemical basis of heredity, and it was nine years later that Watson and Crick demonstrated the structure of DNA. These two discoveries, key to the development of modern genetics, were of enormous importance to basic and clinical science, but also contributed to the creation of other significant social and ethical issues.

To a considerable degree, most medical schools in this country at the time we started out were primarily concerned with educating practitioners. Research was a significant activity in a relatively small number of schools, but it was pursued at a modest level. Medical care was not viewed as a pressing concern by the public as a whole, and terms like health-care delivery were not in the common vocabulary.

In metropolitan areas with medical schools, the indigent population received its medical care on the ward services of the teaching hospitals, where the amenities were often limited but the care was usually of high quality, measured by the standards of the time. In respect to social needs, the curriculum included a course in preventive medicine that dealt chiefly with public health matters, such as control of infectious disease and the measures necessary to ensure a safe water supply. Alcoholism was a common problem, addressed in the curriculum primarily in respect to its impact on liver disease. But such current social problems as drug addiction, violence to self and others, teenage pregnancy and abortion received little or no attention, and AIDS of course was unheard of.

Two things, to a large degree unrelated, affected in a major way the role of medical schools in our society. The

primary one was the decision of the federal government after World War II to support biomedical research on a progressively greater scale. The result was that medical science, both fundamental and clinical, assumed a far greater role than it had ever had previously. Many medical schools and often their teaching hospitals expanded their faculties substantially, concomitantly enlarging their physical plants, a process that is still going on. In turn, as new discoveries or even promises of discoveries became publicized by the media, the public became interested in obtaining the potential benefits. A new relationship evolved between society and the institutions responsible for medical education, for most of the nation's biomedical research, and for an increasing share of patient care utilizing sophisticated technology.

In my view, a second factor was the upheaval of our society in the 1960s that accompanied the civil rights and the free speech movements, which began in Berkeley in 1964 and spread to many other educational institutions. The turmoil associated with the Vietnam War, the advent of the drug culture, and the many other rather major changes in attitude and behavior on the part of large segments of the population, notably young people, affected society and had its impact on the environment of most medical schools. Such changes, based on my personal experience at Stanford, were seriously disruptive and counterproductive, and Stanford was by no means the only school affected. The net result was that medical schools found themselves much more involved in the social problems of the larger society. That involvement has persisted although fortunately some of the emotional overlay has modulated.

While all this was going on, and despite the distractions alluded to, medical science continued to move forward at an increasing rate, bringing new understanding and enhancement of medical capability, but at the same time, increasing the public's expectations and escalating the cost of medical care.

Modern technology has opened up exciting opportunities and benefits for both research and patient care, but the associated costs have created serious problems. Further, the ethical dilemmas that have resulted from our ability to prolong life, even when ultimate recovery is not possible, have brought to the fore the need for decisions for which there are no universally accepted courses of action and questions for which there are no easy, and frequently no definitive, answers. Nonetheless, physicians now in prac-

Sarah Donaldson, George Ellsworth, Suzanne Boulter and Lois Dow all returned for their 25th reunion.

tice and those about to enter it, whether in academia or outside of it, must be prepared to confront these issues.

The allocation of resources for health care was not much of a problem when our class graduated. For example, the definition of death was simple in those days: when the patient ceased breathing and the heart stopped, he or she was dead. Cardiopulmonary resuscitation had not yet been introduced, and life support devices did not exist. Even terminal EKGs were not commonplace.

Consider if you will, the impact of organ transplantation, in which our distinguished classmate Joseph E. Murray '43B has played such a key role. How do we decide whether there should be an age limit for recipients? How, in the face of increasing demand, do we allocate organs, the availability of which is grossly inadequate, to meet the demand? How in an era when resources are limited do we decide how they are to be deployed?

We do a poor job of immunizing infants and children against disease even though the per capita cost is minimal. Indeed, we rank behind countries like India, Thailand and Mexico in this regard. Meanwhile, therapy is introduced for relatively rare, albeit devastating, entities like Gaucher's disease, involving enormous cost.

Since the advent of the antibiotic era, many bacterial infections, which formerly called for hospitalization and carried a high rate of mortality, have responded to treatment, often on an outpatient basis. Pneumonia, primarily that due to the pneumococcus, once described as the old man's friend, became a curable disease. Coupled with other dramatic advances in medical and surgical therapy, life expectancy has lengthened and the field of geriatrics, certainly of immediate concern to many of us, has come to the fore.

What with coronary artery bypass, hip and knee replacement and pacemakers, people are living to the ages where other entities—such as Parkinson's disease, Alzheimer's disease, and massive strokes—bring new challenges in terms of appropriate care. Today, intensive care units in many hospitals, at very high cost, care for individuals in their 80s and 90s, some of whom are in a vegetative state and almost certainly won't recover.

photo by Barbara Steiner

John W. Madden '58 and Suzanne Sims '96 spend a Morning in the New Pathway.

Much of modern therapy is extremely expensive—for example, transplants and neonatal intensive care—as are many diagnostic measures, such as MRI, CT scans and endoscopies. Some diagnostic measures are admittedly over-used, but in large measure they have their place. But sooner or later, and probably sooner, we will have to decide what we can afford. Should there be an age limit beyond which organ or bone marrow transplantation, hip replacement and coronary bypass should not be available? If so, who will make the decision and on what basis?

I can't help but remember an experience I had in the late 1950s when I was dean of the University of Colorado Medical School. We were seeking funds for construction of a new university hospital and research wing and at the time the project was the most expensive the state had ever considered undertaking. One of the members of the legislative budget committee expressed his concern about the amount of money being requested, implying it was excessive. I responded by saying that inasmuch as the funds would ultimately benefit the sick and suffering, cost was no consideration! Although we were successful in obtaining the financing, I would not be able to answer the same kind of question today.

Progress in genetics, previously referred to, has led to the human genome project and has opened up the prospect of gene therapy with potential benefit to patients, but again at high cost. Extremely vexing questions in terms of how the new knowledge is to be used must be faced.

All of the foregoing seems to me to make it mandatory that the medical school curriculum expose students to these issues. They will face them repeatedly in the course of their careers, and they will have no choice but to deal with them as they care for patients. They should also be encouraged to emphasize to patients the advisability and the promise of appropriate lifestyles as a means of maintaining good health at little or no incremental cost.

It is not an easy task to craft a course or courses of study to prepare students for their responsibilities in matters of ethics and public policy. And this situation will not be static; as new advances are recorded, new issues will be generated. As every dean learns, getting curricular time for any course is a major challenge. It is difficult enough to provide medical students with a state-of-the-art education in the art and science of medicine.

It is encouraging to note that our alma mater created a Division of Medical Ethics, and is exposing medical students to ethical and social problems as part of the New Pathway. Other schools are directing attention to the same subject. There is obviously no single approach that will be universally applicable, but medicine and society are far more closely interrelated today than ever before, and it is not possible for the ivory tower of academia to divorce itself from the hurly-burly of modern life.

I am encouraged by the interest I see in today's medical students in respect to many of the problems I have enumerated. I believe they do recognize and take seriously the responsibility of physicians in our society, and, as they take their proper place and exert their leadership in the new century fast approaching, they can be expected to keep firmly in mind the social needs that inevitably impinge on medicine.

Robert J. Glaser '43B is trustee and director for medical science of the Lucille P. Markey Charitable Trust, consulting professor of medicine at Stanford University, and president of the Harvard Medical Alumni Association.

photo by Barbara Steiner

Stephanie Pincus '68, president-elect 2 of the Alumni Council, listens to classmate Deborah Goldberg make a point during the scientific symposium.

Alfred Goldberg, PhD, professor of cellular and molecular physiology, talks about protein degradation in cells as part of the basic science portion of the reunion's scientific symposium.

photo by Paula Lerner

Joy's Trick

by Michael A. LaCombe

I WOULD LIKE TO START WITH A CONfession and tell you something that I have been keeping from you for 29 years. I think this is a very appropriate time for me to come clean about this.

On the first day of medical school, 29 years ago this fall, I was in line to rent a microscope. When it was my turn to get a microscope, I found that Jim Holloran had taken the last one. I got on the MBTA to Cambridge and found the store where the medical school said we could buy microscopes. There I introduced myself as a Harvard Medical School student, and said I'd like to get a microscope.

The fellow said, "Well, how much would you like to spend?" And I said, "Well, I'm going to Harvard so I want the best one."

I selected a beautiful Zeiss binocular with a wooden case. The fellow said, "How would you like to pay for this?"

"Well, I'm on scholarship," I said, "but the dean said that this is all need-blind and I can have whatever money I need.

"Charge it to Harvard Medical School."

I brought my microscope back on the MBTA and immediately went to the room of the one friend I had made thus far.

"Rishon," I said, "I want to show you what I did."

He looked up from his messy room, and said, "Very clever," then added, "It's not going to work."

A couple days later I had to find Dean Gardella's office. I went in, saw the football picture on the wall, and thought that this was going to be a piece of cake, that we'd talk about football and such. But he was in what you might call a rage. He had the bill from the microscope store and he wanted to know what this was all about.

I told him that it was Holloran's fault, that he had taken the last microscope.

That didn't work.

I told him that Rishon had said that I was very clever.

That didn't work either.

It's a story that is metaphorical for society. I knew what I wanted, but I didn't know what I needed, and I didn't know how to go about getting what I needed. I had no idea what the ramifications would be of getting what I wanted. I had no idea what it might cost my little society here, or the implications of doing something that maybe some of my classmates might also do. I had no idea whether what I wanted and needed and what I had gotten would be something that I'd need in two or three years.

Back to the issue at hand. Should medical schools respond to what society wants? My answer is an absolute, "No!" I have several reasons for this and I don't think I'm going to have time to tell them all. But I feel medical schools, and Harvard Medical School in particular, should do just the opposite, which is just what my Class of 1968 would have done at any rate, had anyone told them what to do.

I am very nervous about what I see in medical education today. I see medical schools that select people from rural areas because studies have shown that those young physicians will go back to these areas to practice. I am not comfortable with this.

(In fact, I have known a handful of people from big cities who have actually turned out quite well despite that disadvantage.)

I see medical schools being funded by millions of dollars to institute primary care pathways, and I have been party to talks about equipping these young, primary care internists and family care practitioners with the tools of decision analysis and algorithms and sending them out into the real world so they can decide where to refer patients.

I have a problem with that. I heard a talk yesterday from a classmate whom I admire greatly, who said that the future doctor needs to know how to use algorithms, and when not to use them. That last proviso is a very important part of being a doctor, especially a country doctor.

I see a lack of mentoring, and Dan Federman has told you what the New Pathway is doing about this. I have never personally had any complaints about mentoring at this medical school, and I dare say that had you been privy to the scientific sessions yesterday where my classmates talked about their endeavors in the basic and clinical sciences, and mentioned names like Kuffler, and Hubel and Weisel, and Joe Murray and Paul Russell, you would see that there have been no lack of mentors.

I would have added a couple more myself had I been speaking yesterday. I would have added Erik Erikson, who on the very first day of medical school,

in anatomy lab, told us we were privileged to be here. When I am treating a patient with advanced breast cancer, or I am in the operating room putting in a permanent pacemaker, I remember those words in a different context. I'm privileged to be here. I am lucky to be here.

And I remember another mentor, Dan Federman, who told me when I was a fourth-year student that it was perfectly okay to take care of patients.

But let's not kid ourselves: Harvard Medical School and many medical schools like it do shape what its graduates do. I would like to see our school do something more. I wonder what would happen if the AOA (Alpha Omega Alpha) award were bestowed on those third- and fourth-year medical students who were the finest clinicians. And what might happen if the Soma Weiss award were given to one or two medical students who were the very best in physical diagnosis? What message would that send?

What would happen if mentors, instead of seeking self-affirmation, told young students they could be absolutely anything they wanted to be, that the doors were open to any field, that you were neither too bright to be a surgeon nor too dumb to be an internist?

I remember an essay from the early 1970s by Lewis Thomas '37, in which he said that no one who was a science major in college should be admitted to medical school. That essay prompted an avalanche of positive letters to the *New England Journal of Medicine*. Has anyone done anything about it?

If we need people to hold hands, if we need people to embrace patients and to understand, we need humanism, and you don't get that at birth. And you can't expect a medical school to give that to you. You get that through reading, through vicarious experience, and if you are deprived of that during your college years in the interests of physical chemistry and calculus, then you are the less for it as a physician.

I want to tell you one other story. I think it was about a year ago that Dan Federman called me up and asked if I would take a second-year student for a while in my practice in Maine. I was thrilled, honored. Send him up, I said. Well, fall came and I arranged to meet this student in the lobby of our 50-bed hospital. I was on call that weekend.

In he came—a tall, gangly, lovable kid. I took him right into the intensive care unit where I had just admitted an amitriptylene overdose. The IC nurse on that Sunday was a very bright,

Alvin Poussaint, faculty associate dean for minority affairs, talks with Bernard Godley '89 and Vanessa P. Haygood '78 at the Coleus Society reception.

J. Gordon Teter and Joseph C. Snow from the Class of '48 on Alumni Day.

assertive woman who reads a lot and asks the right questions.

"Dr. LaCombe, why didn't you use physostigmine here?" she asked.

I mumbled something about vital signs, that there was no hypothermia, and the blood pressure was okay. Then this student started talking about 'how in Boston we don't use this because it lowers the seizure threshold'. Then he starts talking about the fields of Forel, and the plains of Abraham, and I'm thinking to myself, I'm a dead man. How am I going to teach this guy anything.

We went home that night and were sitting around the stove and I said, "Now, Martin, you're in your third year. How much exposure have you had to patients?"

"Well," he said, "lots."

I said, "Do you still have Introduction to the Clinic and that sort of thing? Have you ever examined a patient?"

"I'm a third-year resident at the Brigham," he said.

"Federman said that you're a student," I said.

"He calls us all students," he said.

"Would you do me a favor?" I asked. "I would rather not tell my partners about this. I want them to think that all second-year Harvard Medical School students are just like you."

This "student"—whom Ingrid and I have since adopted, one, because we have always wanted one of our kids to go to Harvard Medical School and, secondly, because he is a composite of our three boys, being very brainy, being a very lovable flake, and being someone who can fall asleep with a light on—went on rounds with me and stuck with me like glue every minute. He helped me admit patients to the intensive care unit. He put in temporary pacemakers, scrubbed in when I did permanent pacemakers, and put in right heart caths for me. He watched me do liver biopsies; I let him do a few. We managed chemotherapy together.

And all of the time he was saying, "A monkey could do this. Why aren't they letting me do this at the Brigham?"

I said, "Martin, do they let you take care of AIDS patients?"

"Sure!"

"Which is more complicated, Martin, a Swan-Ganz catheter or an AIDS patient? Which is more complicated, a bone marrow transplant patient (which he said he could take care of with his eyes closed) or a permanent pacemaker?"

Toward the end of his time with me he came up to me very upset. He looked like he was about to burst into tears.

"I want to present a patient to you," he said. He took me down to a room and there was a little girl about three years old with black eyes and a cast on her arm. She was exhibiting the kind of behavior psychiatrists would recognize as over-receptive. In other words, she was your typical abused kid.

"I think this little girl is being abused," said Martin. I agreed.

And he said, "Well, I read the chart and the doctor admitting her said that this was secondary trauma from a fall and that she is going to go home tomorrow."

Martin sat down on the floor and he began an interchange with the little girl, who opened up to him and began to talk about what she was experiencing. And he stood up, and now he was crying, and I said, "Martin, you've just saved a life."

Martin is now looking for a fellowship in general internal medicine, having changed his path from subspecialty internal medicine. I never told him to do this. But I simply said that he could really do anything that he wanted. He could be like me or he could be like his mentors at the Brigham.

Martin came back up with his brother for a visit a few weeks ago, and I would say that he looks almost as happy as one of my classmates, Einar Anderson, who combines music with medicine and is radiant. Martin is filled with joy at doing exactly what he wants to do.

So I remind you: "Joy's trick is to supply dry lips with what can cool and slake, leaving them dumbstruck also with an ache, nothing can satisfy."

Michael A. LaCombe '68 is a country doctor in Norway, Maine and is associate editor of the American Journal of Medicine *and the* Annals of Internal Medicine.

A View from Washington

by Atul A. Gawande

AS A COLLEGE STUDENT, I WAS WHAT my friends called "a fashion risk." I would absent-mindedly wear tube socks and dress clothes or other bad matches. Finally, I taught myself to stick to just a few simple, well-proven clothing combinations. So, for the past year I have had two incongruous outfits, which I have dutifully avoided wearing together. I have the suit and tie of a policymaker in government, and the shabby khakis of a medical student (hopefully still in good standing).

But I knew sooner or later someone would give me the chance to put this crazy combination together. I want to thank Dean Federman for giving me that chance by asking me to come talk about the expectations of medical schools from these two perspectives. As you will see, the perspectives fit together more closely than you might think. Let me start with my sense of how government and politicians see medical schools today.

Altogether, the federal government invests $5 billion a year in medical schools—for example, through direct grants, assistance to students and overhead charges on research. States invest even more, particularly in state institutions. Ross Perot is fond of saying government should be run more like a business. In these terms then, what is the public getting in return for its investment?

By any measure, we have gotten a tremendous payback. American medical education has been the most successful of all of our educational institutions. U.S. medical training is highly regarded by the public and the government; Americans have great confidence in the training and competence of our physicians, and that confidence extends around the world. I know because my immigrant parents are among the tens of thousands who came to this country to benefit from the training we have available here.

To many Americans, medicine is one of our few educational success stories. More than any other educational institution, medical schools have fostered dedication, professionalism and seriousness of purpose among students. The public, policymakers and administrators are struggling to create precisely these elements in our high schools, universities and other graduate programs.

Nonetheless, our public investment in medical education has come under keen scrutiny—and not just for budgetary reasons. Many question whether medical education genuinely serves the public good. Increasingly, questions are raised about the types of physicians medical education produces and whether they are the kinds that America needs.

In 1989 and 1990, I worked as policy advisor to U.S. Congressman Jim Cooper; he represented a large rural district stretching 200 miles through the Tennessee hills and mountains. I made several trips there during that time and a constant refrain from the people was to please help them find doctors. I went to Lynchburg, Tennessee, home of Jack Daniels whiskey and one of the better off counties in the district for that reason. My task was to see what could be done about finding them a doctor. The best we could do was arrange for a doctor to visit a few days a month from far out of town. There were at least six other counties like Lynchburg in the district.

This is not an unusual story. A great number of our representatives hear these pleas time and time again. What they see is that medical schools are producing ever increasing proportions of specialists and fewer primary care physicians who will serve their constituents' medical needs. Schools are concentrated largely on the two coasts and even primary care physicians tend to stay where they are trained.

The public respects our medical schools, but expects more for their tax dollars. The struggle is to find effective ways to encourage the development and training of the kinds of physicians our country needs.

Politicians have begun questioning spending for our traditional institutions when they don't create the physicians we need. Some in government have turned to building state medical schools. For example, East Tennessee Medical School was founded by a congressman with the backing of hard-fought-for federal dollars. Though a young school in the Tennessee moun-

tains, it has become a revered institution simply because it has been so successful in producing physicians who stay to serve Tennessee.

Increasingly, politicians are also looking elsewhere when they feel traditional medical schools are falling short. Osteopaths have found a sympathetic ear because of the midwestern concentration of their schools and the high proportion of them in primary care and in smaller towns and inner cities. Despite powerful physician resistance, nurse midwives and practitioners have overwhelming support in Washington. They have been persuasive in showing that their training will serve the needs of constituents and that they will actually go to the communities in need. Policymakers are also demanding more of medical schools and medical students.

My parents attended medical school in India in the 1950s, the fledgling years of Indian independence, and medical students were expected to spend at least part of their training in public service. My mother still has vivid memories of her trials and small triumphs when she and her medical school classmates were farmed out to villages for months to give immunizations.

Similarly, many states are requiring their schools to institute rural rotations with public service components or to establish required family practice rotations. Some are even considering establishing targets for the production of primary care practitioners.

Texas, Minnesota and New York have all launched programs forgiving loans in exchange for service doing primary care in medically needy areas. In my tenure as his advisor, Congressman Cooper led the revival of a similar program—the National Health Service Corps. And my new employers, President Clinton and Secretary Donna Shalala, have given a strong commitment to its healthy expansion.

On their own, these programs will provide real help to needy communities. But the effects will be limited and the problem won't be solved if programs only seek to hold medical schools and medical students more accountable. The sources of the mismatch between our medical workforce and our country's needs lie fundamentally in the distortions of our health system today.

We have a system in which even the well-insured are often not covered for preventive and primary care. We do not have universal coverage, but we cannot turn away the desperately ill. As a consequence, we spend our public

E.J. (Ted) Beattie, Sid Luria and Robert Smith from the Class of '43A have a laugh on Alumni Day.

Moderator Daniel Federman '53, William McDermott '42 and Doris Bennett '49.

and private dollars on care for illness, especially catastrophic illness, and not for health. Our health dollars are concentrated in hospitals, treatment facilities and specialty care, not in preventive and primary care.

As students we receive from medical school not only training, but also exposure, mentors, glimpses through the doctors we meet of the roles we will come to play. We may not realize it, but we expect medical school to guide us to a new life and not just a new profession. And medical school does.

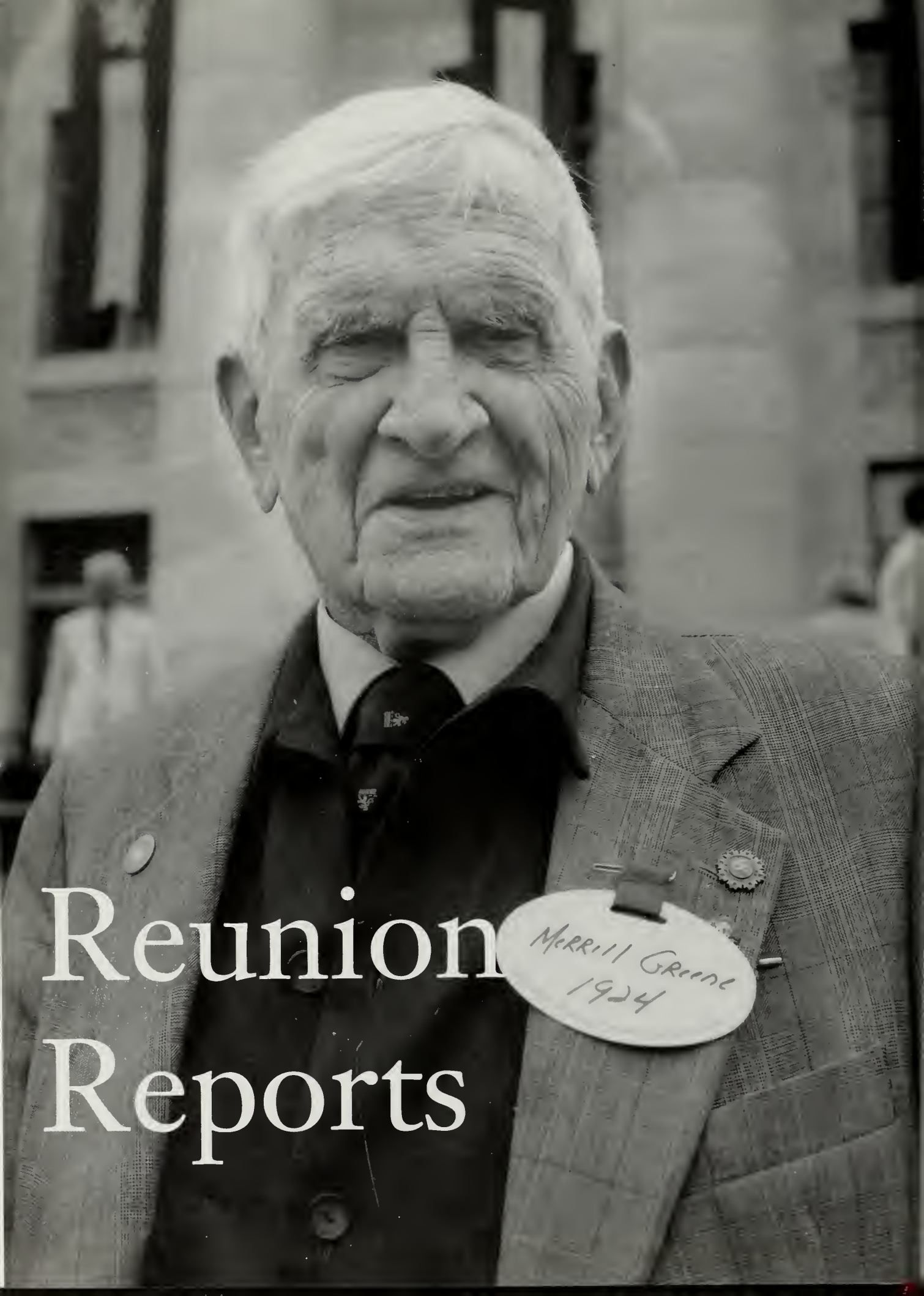
We are largely trained in hospitals—for this is where our health system is focused. We see the prestige, reward and respect going to the heroes of hospital medicine—the cardiologist, the thoracic surgeon and other specialists. The valiant efforts of the New Pathway to emphasize primary care will not stop the tides. Indeed, students will often see such efforts as futile experiments in behavior modification.

Unless we reform medicine to provide universal coverage for primary and preventive care, and not just acute care, and unless we reward primary care physicians with assured coverage for their services and the guiding role in their patients care, reforms in medical training will have only modest effects. We students will continue our surge into specialties. We will stay on the coasts where we are trained. The public and politicians will grow more frustrated with the public investment in medical schools. And the distortions and needs will remain.

So in my shabby khakis and my coat and tie, I can tell you: What do students expect of medical schools today? Solid training, wide exposure, mentors, and guidance for a changing and demanding future. And what does government expect of medical schools today? More and more, as with health care as a whole, it is change.

Atul A. Gawande '94 is on leave from HMS to serve as senior advisor to the assistant secretary for planning and education, U.S. Department of Health and Human Services.

Garry Hough III '48, Reid Pitts Jr. '67 and Phil Goldsmith '67 queue up.



Reunion Reports

65TH

THIS YEAR, BEING THE ONLY MEMBER of the Class of 1928, I was lost! Genial Joe Murray was wonderful and compassionate, as I had lost my loving wife two weeks previously after seven years of a prolonged illness. I went to the reunion because I promised Marshall K. Bartlett that I would be there. I did meet John Monkes' daughter who introduced herself to me when she saw that I was from his class. I enjoyed reminiscing with her about her father. She and her husband were young, vibrant and understanding individuals. I should have mentioned to her that I knew about her grandfather's monumental work on the circulation of the bowel. It would have added some happiness to her memories.

I was accompanied to the reunion by my son and daughter. I enjoyed showing off HMS to them, especially the courtyard with statues of some of my professors included.

We had a fascinating hour sharing luncheon with Merrill Greene '24. He spoke of his experiences as a primary care physician in Lewiston, Maine and he still assists from time to time with medical examiner duties. He served as some type of legal magistrate during World War II. One of his legal decisions was reversed but that didn't bother him! He was bright, very witty and had many stories and jokes to liven up the day. I was glad I attended my 65th reunion and so were my children.

Anthony V. Migliaccio '28

60TH

THE CLASS OF 1933 CONCLUDED Alumni Day with a dinner at the Harvard Club. Our motto "We made it" was symbolized by a logo designed by a Cannon granddaughter. Fourteen classmates were present, accompanied by wives or friends, and Reid Pitts '67 brought his handicapped father, Bill Pitts. The two morning sessions stimulated much discussion about our relationship to patients. We recalled our role models, the venerable clinical teachers under whom we studied. Quotations were read from early and recent writings of classmates, proof that we had not forgotten the importance of caring for the patient.

Earlier in the day, mountaineer Ken Olson met his fellow climber Brad Washburn (Museum of Science) under whom he served as physician on an expedition to Alaska in the summer of 1930.

After one year at HMS we knew it all only to learn later how little we knew. Widower Joe Lichty, who is missing in the picture, spends his travelling days visiting immobilized classmates and their widows. He proved a source of information about the status of those who have been remiss in communicating. Loquacious Francis Murphy reminded us of advances made during our student years, such as the first excision of a ruptured intervertebral disc, and expressed doubts about the New Pathway program. Leo Walzer recalled the early use of isotopes in measuring blood flow and the total thyroidectomy for angina.

More personal discussion concerned the benefits and shortcomings of various hearing aids and the compli-

cations from the anticoagulant therapy required by some. One of us, asked of his golf handicap, replied, "old age."

It was a happy occasion with a renewal of friendships made many years ago. A feeling of warm affection was very evident as we greeted one another and as we parted on Friday evening, perhaps for the last time.

Bradford Cannon '33

55TH

photos from 1938 Aesculapiad

WE MET THURSDAY AFTERNOON IN the Countway for drinks, talk and a fascinating account of the Nobel ceremony by Joe Murray '43B and his daughter, who is also an HMS alumna. The prizes for medicine and literature are the most prestigious.

At Alumni Day, Dan Federman '53, with his usual aplomb and wit, introduced the speakers and kept questions on target. Michael A. LaCombe '68, spoke movingly about the pleasures of small town practice in Norway, Maine. If you are roaming Maine, you would enjoy meeting this remarkably articulate physician. Ann Landers was the star of the morning. She gave a forthright speech in which she showed no love for psychiatrists. She receives 2,000 letters a day and when in her column she mentioned that HMS could give information on living wills, the school received 60,000 inquiries. Dr. Federman said they had to set up a special office.

During Friday dinner at the St. Botolph Club, we heard from two current HMS students who were enthusiastic about the school and the New Pathway. Students are self-driven to achieve without unseemly competition with one another. The Asian woman was negative on affirmative action; I think the white male was also, but appreciated the social need.

Saturday afternoon, under a blue sky, we had a picnic at Hub and Marge Sise's place in Milton, where we were joined by Edith Kopans and Shirley Burbank.

Age has brought the usual infirmities but confirms our wise judgment of years past and continuing through 50 years or more. Unless separated by death almost all of us are still with number one—something the younger classes don't seem to realize. Attendees (most with wives): Beach, Boger, Brown, Cahill, Campbell, Dee, Gellis, Giddings, Harrington, Jones, C. Johnson, Lepreau, Liebman, Mead, Nelson, Sise, Smith, Strobino, Yankauer.

Frank Lepreau '38

50TH '43A

Our Golden Reunion was blessed by four days of picture perfect weather, close comaraderie, and numerous activities. The classes of '43A and '43B became one again as they have at each reunion since graduation. The reception held in the Common Room of Vanderbilt Hall on Wednesday evening set the mood for the gathering of old friends. We noted the hall had not changed as much as ourselves, and the students appeared much younger! Congratulations to Henry Allen who was honored by the Eye and Ear Infirmary last week by having his portrait unveiled in tribute to his outstanding contributions while chief of the infirmary!

The following evening we were graciously hosted to a delicious clambake by Dorothy and John Brooks at their beautiful home in Weston. Once again '43A is indebted to the Brooks for adopting us, as they have in the past. Also we thank Elliot Sagall for a job well done, as Transportation Chief—including his stretch limousine.

Friday, the alumni symposium was stimulating, instructive and entertaining, featuring Bob Glaser '43B, Eppie Lederer (Ann Landers), Michael LaCombe '68 and Atul Gawande '94. Jim Jackson, class agent, presented the hefty class gift of $171,000. (Not bad.) We were pleased and honored to have Ruth and Arthur Guyton present. Arthur has distinguished himself as a noted physiologist, but in addition, Ruth and he have produced 10 children. All are physicians. Eight of them have graduated from HMS (*Guiness Book of World Records*—please note.)

The final two days were spent at the picturesque Weekapaug Inn in Rhode Island. The weather, service, food, etc. were perfect. The assorted activities demonstrated that many in our age group have retained their athletic stamina. Charles Kane gave an excellent discussion on disease.

A period of solemn respect was dedicated to our deceased classmates. The name of each classmate was called out, followed by a period of silence.

Peirson Richardson so aptly wrote: "The inevitable sadness that we feel at their passing is tempered by the realization that each made a particular addition to the positive side of humanity's ledger. Let us remember them and how much they meant to us."

We took leave of one another on Sunday morning to return home with the fond memories of a truly great Golden Reunion.

Finally, the class thanks and deeply appreciates those who contributed so much to make this reunion so meaningful. Peirson Richardson, who has edited and published our class books since graduation. Allan Friedlich, our treasurer, who has held the purse strings for five decades, and Jim Jackson, our caring class agent, who has striven to keep the umbilical cord intact by frequent and fraternal correspondence. Also to Nora Nercessian and Eva Grubinger of the Alumni Association, who so skillfully and kindly guided us in planning this 50th reunion.

Don McLean '43A

50TH '43B

THE WHOLE REUNION WEEK WAS excellent in every way. The Wednesday gathering at Vanderbilt Hall took me back to school days. The Thursday symposia at the medical school were excellent. The gathering in Weston was beautifully catered with clams and lobsters. There were 155 of us there. Friday morning was very stimulating with speeches by Bob Glaser and Eppie Landerer. Eppie (Ann) was amusing about psychiatry. The question of house calls came up for discussion and a lot of us agreed that you can't do everything in medicine.

Then we went to Rhode Island to the Weekapaug Inn where 91 of us had a wonderful time recalling old times, singing, telling stories and enjoying the seashore. On Saturday in the late afternoon we recalled some 80 members of our classes '43A and '43B who have died and who have been and will be missed.

The general tenor of the reunion was one of happiness in various degrees of retirement. There were no regrets about our lives in medicine and continued warmth for HMS. We look forward to 1998.

John R. Brooks '43B

45TH

THE CLASS OF 1948 BEGAN ITS reunion in the atrium of the Medical Education Center with over 50 husbands and wives attending. Some members were retired and some were planning retirement within the next year. Dean Tosteson gave a short welcoming address to his classmates. After the alumni activities and photographs on Friday, the members of the class enjoyed the hospitality of the Alumni Association for a Quadrangle luncheon and then departed for Stageneck Inn in York, Maine.

Activities included tennis, birding and a nature walk and trekking around the rocks and streets of York Harbor.

40TH

From as far as Washington State in the west and Hanover, Germany in the east, the Class of 1953, represented by approximately 35 members and their spouses, celebrated their 40th reunion in style. On Thursday, June 10, a dinner dance at the Bay Tower Room proved a spectacular setting for getting reacquainted and reviving old memories, talking about professional activities as well as about our expanding families and particularly looking to the future, including retirement or other alternative careers. On a less serious note, our old 1949 "mug" shots proved to be a humorous icebreaker!

On Friday, as "old hands" we registered in Building A and couldn't quite believe that it was 44 years since we had first entered there as freshmen. The Thursday symposia as well as the Alumni Day presentations provided us with discussions that continued into Friday night. The latter time was left open for informal, spontaneous dinner gathering at various old and new eating spots. A beautiful summer day greeted us on Saturday for sightseeing in Salem with a special tour of the fascinating Peabody Museum before going on to Rockport for a lobsterbake, enjoyed by all, at Virginia (Ginny) Powell's new home. Our thanks are extended to her for her gracious hospitality. Everyone agreed that we had "mellowed" now that there were fewer "mountains to conquer" and we enjoyed a comradeship that was stronger than in past years. We hope all will return for those days in June of 1998 when we celebrate our 45th HMS reunion.

Iolanda E. Low '53

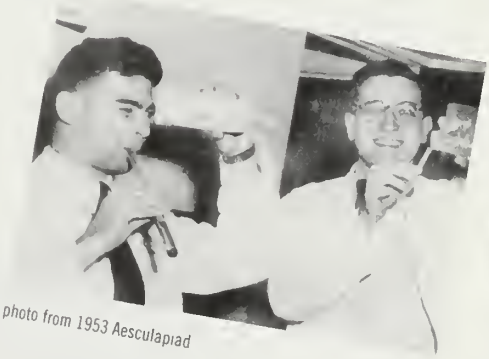


photo from 1953 Aesculapiad

Even the ocean had warmed up for pleasant swimming. On Friday afternoon the class met in a circle to relate the most interesting events in more recent years. There, under beautiful blue skies and with amazingly blue water, they renewed acquaintances in discussions centering on the present changes in medicine, hilarious episodes recounted from past medical experiences, and brief summaries of each person's activities in the past five years. Having the wives speak first was truly delightful and the candor and spontaneity of their observations were truly appreciated by their husbands. Names and faces and attitudes were much easier to identify after that session and for those of us with hearing problems the measured quietness of the format was most appreciated. After that a 30-minute reception before dinner was all that was necessary.

The next afternoon an even larger group met to draw up priority guidelines that our collected rank and file experience would give to the Health Care Task Force as it approached its mission to design a more efficient, cost effective medical care system. Again this was extremely well received as an alternative to a noisy dance band. After dinner the class enjoyed a round of light-hearted professional anecdotes, each classmate making a brief contribution. The excellent weather, accommodations and setting were more than a proper celebration of our 45th. Of the 70 members and families at the Thursday night reception, 48 made the trek to Maine. All look forward to the 50th reunion and warmly wish that some close friends not present for the 45th will join us then. The organizational committee was impressed by the excellent logistical support and advice given by the Alumni Office, which shared immensely in the success of the reunion.

James A. Bougas '48 and C. Newton Peabody '48

35TH

THE 35TH REUNION WAS HELD IN Boston this year—a first for our class which has traditionally met in Boston and then gone to a resort for the weekend. This year we spent Thursday night at a splendid waterfront reception at Hugh Chandler's home on Lewis Wharf. On Friday we gathered after Alumni Day exercises on the medical school Quadrangle. Had the usual luncheon and had our class picture taken. That evening we held a fine dinner dance at the downtown Harvard Club, which was attended by 80 people. The finale on Saturday was a clambake and outing on Thompson's Island in Boston Harbor, which was blessed with sunny weather and left us with many warm remembrances.

This year several people returned for the first time to a reunion. After 35 years, Jim Hall, Hugh Harris and Rudy Pierce returned and said they would definitely be back again. Others returned who had not been back for 20 or 25 years, and agreed it is more fun as we all get older. By a majority vote, it was agreed to return to our habit of a weekend reunion away from Boston, which allows for a longer and more informal retreat. We are urging all members of the Class of 1958 to put June 1998 on the calendar for our 40th medical school reunion.

Jeannette H. Corwin '58

30TH

THE CLASS OF 1963 GATHERED ON the lawn of Irene Briggin's house and enjoyed one another's company and a wonderful meal (made by Irene for the most part) as we discussed careers, children and even grandchildren. Irene had picked perfect weather, so some of us ate on the lawn. Harvey Klein arrived late, having endured a plane ride that would have daunted Indiana Jones.

A group of us attended the scientific sessions, others enjoyed the weather another day. Friday evening we enjoyed an excellent dinner and chamber music by medical student musicians in the atrium of the new Medical Education Center. We tried to figure out how this new building related to the old buildings; it was like stepping through the looking glass. There were after-dinner speeches and a performance by Dick Brubaker. Luckily, there were only threats of performances by the cast of the 1963 second-year show.

Since we all agreed that we were looking better even than we looked 30 years ago, we were encouraged to return for our 35th.

Kate Wolf '63

25TH

THIS GET TOGETHER, WITH PLENTY of classmates attending, should have been subtitlted: All Things Change, All Things Remain the Same.

Some impressions: Thursday's scientific sessions were incredibly good, not just for the excitement of seeing what classmates have accomplished and where they have arrived, but also for their intrinsic scientific interest. Amphitheater D was packed all day, until after 5:00 PM. Fred Goldberg began a fascinating unraveling of the mystery of how and why intercellular protein degradation takes place, became more and more enthusiastic, began to pace and wave his arms, and soon ran overtime. Stephanie Hoyer Pincus raised her hand, told Fred to end it, sit down and give Mickey a chance to talk. We knew we could count on her.

Bob Colvin talked about graft and corruption. He is from HMS. I was struck by Andy Weil's insightful, organized presentation of alternative medicine, and the use of botanicals in present day therapy. Einar Anderson, who has successfully combined medicine and orchestral conducting, easily appeared to be the happiest of the bunch. And Steve Pauker, with wit, humor and brilliance, stole the show in the afternoon.

There was a luncheon this day, and you will be interested in how people appeared 25 years later. Nina Tolkoff-Rubin and John Bullock have not changed one bit. Nortin Hadler and Lois Dow look better. Fred Orkin looks exactly the same, except for a beard. But the beard hasn't the decency to have one fleck of grey; it is jet black.

Ben Furlong did not recognize me.

Friday morning was Alumni Day, and David presented our class gift, which incredibly topped the reunion gifts of the classes of '43A and '43B, despite the fact that none us us is rich, and no one has won the Nobel Prize, yet. Ann Landers spoke and was, as one might expect, direct, honest, quick thinking and brilliant. She took on the psychiatrists. This prompted Rob King to approach the microphone for a comment.

Understandably a bit nervous in Ms. Landers' shadow, Rob, instead of saying he was from the 25th Reunion Class, stammered, "I'm Rob King, Class of '25." "You look good," snapped Dan Federman.

There was a luncheon after this, with a lot of milling about, and then our class picture. No one seemed to want to leave. Dave Perkins was there looking, shall we say, like a prosperous and "settled" ophthalmologist. Vince Reale, frantic violinist and plastic surgeon; the lean, fit rabble-rousing Eric Chivian; and Mike Ascher, who appeared to me as might a Philadelphia banker, were all there on the steps of Building A. So was Susie Boulter, who looks like she skis four mountains per weekend, and Jan Breslow and Ken Prager, leaders in their fields, looking like they owned the place. Lincoln Chen, with his peripatetic life, is still trying to contract tropical disease. Ed Seldin hadn't changed. Bob Dolgoff and Bruce Schneider had, but only a little.

I thought I could feel Rishdon, Donna, Jim, Jack and Carlton there, and Laird and I talked about that—but I really missed seeing Bruggerman, Cohen, Garrison, George Goldberg, Grana, Hochschuler, Jakobiec, and my lab partners Kluft, Kolonel and Krauss. None of them showed up.

I didn't recognize Ben Furlong.

But the highlight for me personally, despite quality time with Dave Oyer and Dan Onion, was this: Ann Landers told me she loved my shoes!

Michael A. LaCombe '68

photos from 1968 Aesculapiad

20TH

THE WEEKEND OF JUNE 10 TO 12, 1993, saw the regathering of the 20th reunion Class of 1973. The turnout was gratifying. Forty classmates attended at least one of the functions and our numbers swelled with spouses and children. Planned by Peinert, Tully and Zitin (with the expert help and advice of the Alumni Office), the weekend offered a varied and interesting series of events, but the most enjoyed and significant activity was that of BEING TOGETHER AGAIN!

After the HMS scientific symposia on Thursday, our class gathered at Vanderbilt Hall for a reception and the beginnings of the "catching up" process. Friday started with the Alumni Day program and luncheon and ended with a dinner cruise on Boston Harbor. The clouds threatened all afternoon, but the drizzle only began in earnest as we arrived at Rowes Wharf to board the "Gracious Lady." With eager anticipation, we walked past the sleek and elegant "Spirit of Boston" and the dramatic, yacht-like beauty of the "Odyssey" to feast our eyes on the rather inelegant, ungainly, slightly rusty craft that was to be our vessel for the evening. (It looked rather like a brightly painted, massive suppository, bobbing in the wind-blown waves of the harbor!) Luckily, we did *not* have to see our craft once we were aboard, and good food and great camaraderie more than made up for the modest exterior. For over three hours, we toured the harbor, ate dinner and enjoyed our own company. A few intrepid souls braved the open upper deck to enjoy the evening skyline through the haze, but the warm glow was below, with the friendships being rekindled. We returned safely despite all of us ending up crammed in one corner of the lounge, as if trying to stay as close as possible.

Saturday dawned clear and cool, but warmed up through the day. Bright sunshine and Dick and Dina Peinert welcomed us to the clambake in Lynnfield that filled the afternoon. More good food and active conversation enhanced the reunion process. We parted with lots of handshakes and hugs, great memories and promises to stay in touch.

We thank everyone involved in planning and hosting the various activities as well as everyone who made it so special by making the time and effort to attend. We urge anyone who has comments about the 20th or thoughts/suggestions for our 25th to let us know; we especially want to hear from those who did *not* come so we can try to boost attendance and participation. Our awards committee wanted to pay special notice to this year's winners:

Frequent Flyer Miles: to the Californians who made the long trek.

The Willard Scott Prize: to George Tully, our Weather Committee Chair, for his poor showing Friday evening and his brilliant comeback on Saturday.

The "Tip o' the Hat" Award: to all full professors and to Steve Weinberger, who continues to win HMS awards for his outstanding teaching skills.

The "Oil of Olay" Least Changed by the Years Award: to Jesse Thompson, Dave Shahian and Mark Kelley. Also to spouses Judy Thorpe and Patty Rosenblatt. Incredible! You look Mahvelous!

Best wishes to all HMS '73. Hope to see *everyone* in 1998.

Barry Zitin '73

15TH

FORTYSOME MEMBERS OF THE CLASS of 1978 and their families gathered on Friday night and Saturday afternoon to recall old times and catch up on the 15 years since our HMS graduation. "Can it really have been that long?" was a common refrain throughout.

Friday night was old times night, even though we gathered in a new spot—the atrium of the new research building between buildings B and D of the Quad—to get reacquainted. Following a buffet of Thai food, we were serenaded by an oldies dance band unearthed for the occasion by Andy Arnold. For a few memorable moments, they actually got everyone up on their feet dancing to the songs of youth. (What would our kids think?) Unlike old times, however, most of us went home before the band did. (Was it a sign of age or just the press of other responsibilities?)

On Saturday the focus shifted to the present. On a perfect beach day, we enjoyed a family barbeque at the oceanside home of Phyllis Carr in Duxbury. It was a chance to marvel at our collective fertility and the wide age range of our offspring. A surprising number of us brought infants and toddlers—even more, it seemed, than at our last gathering five years ago. While the kids amused themselves throwing rocks into the ocean, wading in the shallow water and chasing horseshoe crabs, the adults spent the afternooncatching up and guessing which children belonged to which classmates.

All in all, it was fascinating and fun to renew our connections with our old friends and classmates, many of whom had travelled a considerable distance to join us. From outside New England came John Douglas (Colorado), Paula Bockenstedt and David Fox (Michigan), Kathy Murray-Leisure (Pennsylvania), Charlie Van Ter Horst (North Carolina) and Steve Tames (New York). In addition to a large Massachusetts contingent were Patricia Williams from Maine, George Record and Eileen Storey from Connecticut, and Amy Schneider from New Hampshire. (My apologies to anyone I've missed). Thanks for making it possible go to Phyllis Carr for hosting us, Andy Arnold for locating the band, Robbie Isberg for editing the reunion report that let us hear from classmates who didn't make it to Boston, and Adrian Gropper and the Alumni Office for helping to organize the events.

Nancy Rigotti '78

10TH

RETURNING FROM OUR TENTH reunion, Carlos and I were pleased to note how little the group had changed. Sure, there were some of the inevitable signs of aging, but it seemed that conversations begun during graduation week 1983 were easily picked up again mid-sentence. Sherry Haydock and her husband, Mason Freeman, hosted a cocktail buffet at their beautiful home on Friday evening. Classmates attending discovered what area of medicine people had ultimately chosen and in what direction they were focus-

ing their skills. At least a dozen of the reunion attendees had chosen a pediatric specialty, but primary care, surgery and neurology were well represented. Most people are in some aspect of research. However, few conversations centered around work. Most discussions compared how classmates managed to balance growing families with the stress of research, deadlines, grants and making a living. Those of us who live and work outside of the established East Coast medical centers were intensely questioned about living and working in a more lifestyle friendly city. We were also asked about the medical climate in Boston.

Saturday, a larger group met at Lars Anderson Park for a barbecue lunch. Children and families were the only topics of conversation. Our class boasted a larger than average number of "class couples" and happily several returned with families in tow. Kids of all ages enjoyed the park and playing together. It was a perfect low stress way to meet and visit all the members of our ever-growing class family. Many thanks to our Boston based reunion planners: Lisa Guay-Woodford, Chris Coley, Ann Taylor, Dana Gabuzda and Sherry Haydock. Applause to those who traveled long distances to attend and we hope for an even better turnout at the next reunion.

Jayne Finkowski-Rivera '83

5TH

OUR FIRST OFFICIAL REUNION WAS characterized by a sense of accomplishment and great expectations for the future. We met at the Vanderbilt Hall Common Room, which has not changed at all since we were first introduced to it in the fall of 1984.

Approximately 20 members of our class came to the reception to reminisce and talk about the future. Pediatricians outnumbered any other specialists. They appeared to be the happiest too! There were no voices of regret regarding specialty choice, even though a few were starting a second residency (as planned from the beginning).

As fascinating as it was to hear about how well our classmates have done during training, it was clear that accomplishments in the personal arena took first stage in most people's lives. Many have managed to get married, have children and still keep their sanity during residency. Among others: Tammy Fountain, Kim Wilson, Karen Sadler, Jodi Heymann, Adam Silk, Sarah Frim and Roger Nuss could not stop talking about the rewards of parenthood. It was also exciting to hear how Arlene Curran, Lynn Weston, and Ed Ryan were able to enhance their training experience by traveling and working abroad.

Overall, we had a great time catching up on life's events. It was encouraging to see the vitality and optimism with which our classmates are entering a life of responsibilities and joys.

Hope to see you before 1998.

Marta L. Davila '88

photos from 1988 Aesculapiad

Three Poems

by M. Donald Coleman

Unveiling (Mother)

These grassy mounds remind us
That seasons, not years, have
measured
Time since you became a thought.
The crafty gravedigger plans
The mound itself will fall
Flush with neighbor grass and flatness
reign.

Will memory, sweet and bitter,
Be our legacy? Each cherished or
abhorred
But counted daily like miser's gold,
And just as sure to slip away
Til we doubt what once was ours was
ever true
And lose ourselves and you in time's
flatness.

We stand here dumb, not knowing
where you are
Or where we stand beyond the eye's
next blink.
Memory is a fragile thing and will not
hold you fast
For us or those who follow.
But what we are is part of you
impacted
With which we will impact the future
in endless chains
Of life effected and transmuted by the
fact of you:
These locklinked chains will bind and
break
Time's pull to flatness.

Home Town Club (Father)

On these grassy knolls I sport myself
this summer day
In my father's image of me: his seer
sucker clad
Harvard boy with white bucks and
disdainful air
Made to measure to help home town
folk
Revise their Doomsday book for such
as me.

Small town guildsmen, trading in life's
notions
Come to front of their not too recently
refurbished shops
The old ones all gone out of business
With long promotions that cried
"Everything Must Go."

The open stalls fit tastes they scarcely
knew they had
So far they were from open stalls of
the Levant.
Here they rest on white stone benches
that mark each portal
And gravely nod to each familiar face
And call the gossip of the town to each
other
Along with business news of interest
As did those first Venetians who quay
side sat
And gave their seat commercial name.

But now they bear no tales of sinking
ships or businesses,
Only pleasant interest at this new face
in their old town
Wondering if I belong to their gentry:
For gentle blood must course my veins
And will admit me blood's forgiveness.

My father, seated on his stone
Stops talking to his partner and the
other storefront syndics.
He turns his gaze toward me, smiles
and waves me to his side.
"Jack Coleman's boy" the syndics
smile and nod.
I'm welcome here, my final club.

Airport at St. Barts

The sun's testament grants generous
bequest
to young blood,
Flaming bronzed bodies reflect luster
of
the source, tamed to brown,
Their drab earth-colored smocks and
jeans are
useful foils to frame skin and
body's wonder.
The tropic airport heat draws no
response
from young pores,
And no sign that this, the end of their
brief week
is cause for anything but counting
more.
They are millionaires with unlimited
checking credits
That they could draw upon forever:
tomorrow
perhaps.

Old bodies too share sun's legacy
as best they can,
Bright cotton dyes drape sun color
round
flaccid skins
Which, baked too long, become mud
brick.
Their pores open paths to bone
That will all too soon be bared.
True millionaires, they know their
finite checking must balance,
And could be overdrawn at any day:
tomorrow
perhaps.

M. Donald Coleman '52 practices psychiatry and psychoanalysis in Westchester, New York.

The Last Day

by Crawford C. Campbell

THE DOOR OF MY LOCKER OPENED with its own peculiar squeal and I gazed with bleary eyes into its depths. There were packages of suture and pens and such, haphazardly strewn across this tin wasteland. These contents represented a good part of my adult life.

How many times in the years past had I run to open and stare into this space, groped for goggles and clogs, and then run away again into the operating room to fix, or try to fix some torn limb, a ruined life, child, lover or friend? I stared into this space and memories poured from it, new memories, different from those before all this had happened.

Before all this had happened. What had happened? I had become locked into this cycle of caring and despairing; of being a doctor, a surgeon. My life had become a journey into other people's pain.

I can still see the reflection in the domed lights of the trauma room of those last moments of life as the chest is cracked and the blood is spilled, and remember the hush as the spirit of the young man flies once about the room and then is lost forever. All these memories had somehow become trapped in this small steel container in the depths of this large, stone hospital,

photo by Stuart Darsch

squatting as it does in what was once a river bottom.

I have long since been afraid—afraid of not doing the right thing, saying the right phrase, learning the right fact, being the right person, being the good doctor. I can smell the fear as I smell the odor of the scrubs tossed on the floor by the impatient surgeons. Am I able, on this day, on this very day, to sweep the tissues away with my finger, with my blade, with my mind and heart? Am I able to create the dream of healing? Am I able?

I can hear the calls of the injured as they echo down long, cold corridors. I can still see and smell the drops of blood as they fall from the stretcher on which people lie, people about whom I know so little. I do not know who loves them, who succors them, who listens to their stories, who is intertwined in their life, who loves the smell of their breath. I know none of these things. I only know the blood and the pain and the desire to make them whole again.

I live in a world of sterile diagnoses, where numbers and statistics mean everything. I lose sight of the essence of the human—the spirit. It does not fit in our scheme of what to do and what to say and whom to call and what equipment we will need to do the job. And, by the way, what radio station would you like to hear above the sound of the saws and drills and the quiet hiss of the ventilator as it keeps the body alive while you do whatever it is you have to do to keep the limb alive?

My legs still ache from the interminable hours of tending to the sick and injured. But this is my chosen life and few understand what it means to stretch across that fragile interface between life and injury and death; that twilight, that spot that we will all someday cross. The trouble is that some people have to watch many make that twilight journey, unwilling, kicking and screaming and praying that it were not so.

I packed my bags with my papers, my sutures, my clogs and goggles. I closed the door that I had opened I know not how often. I recognized its click as the tumblers fell into place. My training was over. My soul was conditioned. I turned and walked the hallways I had walked so many times in the past and then, suddenly, emerged in the sunlight, never to return again.

Crawford C. Campbell '87 wrote this in 1992 on his last day of residency in orthopedic surgery at the MGH. He is now a hand and upper extremity fellow at Brigham and Women's Hospital.

My Dinner with Saint-Exupéry

by Sedgwick Mead

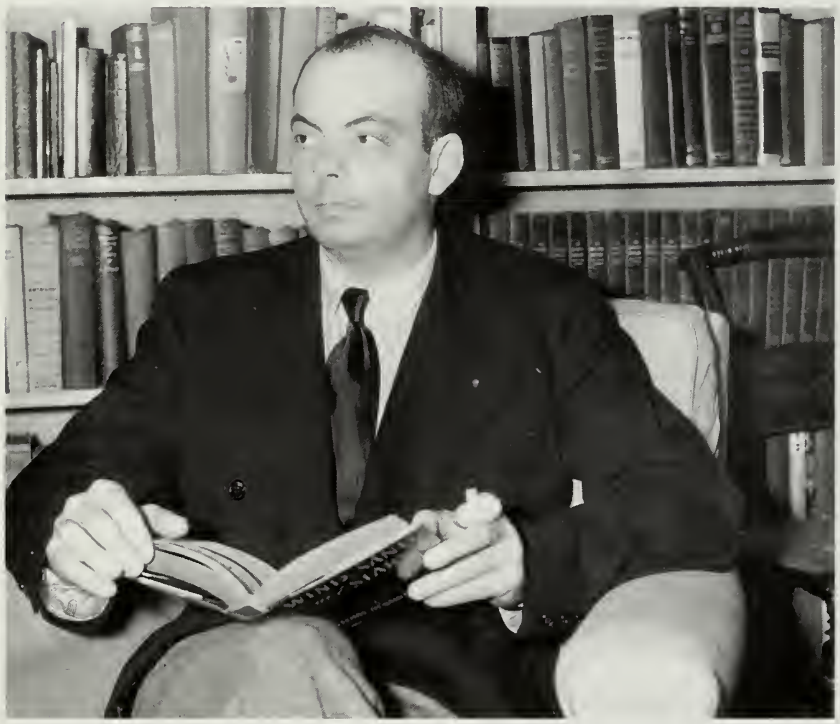


photo of Saint-Exupéry, 1939 by UPI/Bettmann

I SOMEHOW MISSED THE NEWS OF Antoine de Saint-Exupéry's death until several months after it happened in 1944, being, I think, enroute for the Southwest Pacific at the time. In World War II I was an army doctor assigned to the 6th General Hospital and stationed at Casablanca. I had come to know many of the French physicians in the city, one of whom was Henri Comte, acknowledged to be the premier surgeon of the region. On occasion, I had been a guest at his beautiful villa on Anfa Hill, near where Roosevelt and Churchill were lodged for the second of their historic conferences.

The news of Saint-Exupéry's death set me thinking about my only meeting with him, in September 1943. I reflected that it would have been better had he died before May 1940—the time of the fall of France to the Germans—for in 1943 he was clearly a broken-hearted man. Not knowing that I would meet this famous writer, I had accepted an invitation to dinner at Comte's villa, with its formal garden and deferential Arab servants.

I found Saint-Exupéry to be a tall, big, rather bulging man, balding a little, and rather homely. He was dressed in American army drab, with the four *galons* of a French major on his shoulder straps. There were crinkles about his intense brown eyes and he seemed generally preoccupied, as if it were a constant effort to recall his whereabouts. His smile, however, was infectious and his manner friendly and genuine.

I chaffed him gently about his failure to learn English after having resided for two and one-half years in America.

"*Mais,*" he protested, "*il n'y a pas besoin; tout le monde à New York parle parfaitement Français!*" And of New York he said, "Why it is tiny, intimate even. I cannot walk down Fifth Avenue without meeting someone I know!"

Of course! The New York where Saint-Exupéry was ensconced in a sumptuous Beekman Place suite, the French-speaking New York, the New York of artists and literary folk, *was* tiny. Saint-Exupéry had achieved worldwide renown and instant prosperity after publication of his book *Terre des Hommes*. Retitled for English readers, *Wind, Sand and Stars*—with its inspired translation by Lewis Galantiere—it was a Book-of-the-Month Club selection.

I spoke to him of my admiration for his work, which—excepting only certain passages of the Old Testament—is the most intensely poetic prose I have ever read. He was pleased, too, that I had recognized another quality—his feeling for the earth, not merely as a flat place to walk on but as an evolving, pulsing, living organism. Always his

questing mind found metaphysical resonance to the beautiful or awful things he saw, lifting reportorial observation to a height of profoundly religious illumination.

Fascinated, I listened as he talked volubly all through dinner. He had been up to Algiers to the North African Military Command Headquarters, where he had offered his services to the Americans but had been politely turned down—a little elderly, I gathered, for a combat aviator. In the talk that ran from the Russians to Eve Curie, De Gaulle received brief, chilly consideration. I asked him his opinion of the Hans Habe book *A Thousand Shall Fall*, which pictured French generals in a poor light. Saint-Exupéry flushed with anger at mention of the book and we dropped the subject.

Brimming with fun, Saint-Exupéry reminisced about his old days in the South American air service. While he was an agent for Air France in Buenos Aires it was his duty to show visiting *grosses legumes* (big shots) the points of interest in the city. After he had finished, they invariably would ask in a confidential whisper if he could add to his tour a visit to the city's gaudiest and most exclusive bawdy-house. One such occasion happened to fall on Good Friday. When the small group entered, guided by Saint-Exupéry, to their amazement they found no one. Puzzled, they went from room to empty room. The trappings were all there, but not a single bedizened lady of the evening.

At last, followed by his tiptoeing guests, Saint-Exupéry entered a small back room, which, to the astonishment of all, turned out to be a tiny chapel, complete with altar and crucifix. The candlelight dimly disclosed figures kneeling at the altar, where no priest presided. "Hola!" shouts Saint-Exupéry in Spanish. "Where are you, little turtle-doves?"

Furious, one of the women gets to her feet and fixes him with an angry stare. "Silence, barbarian!" cries she. "Don't you know that on this day our Lord is dead?"

Finally, over the coffee and cognac, I rather clumsily uncovered the wound he had been shielding. When I spoke of France's shameful collapse and the toadying Pétain regime, he reacted like a mother bear whose cubs are threatened. I expressed my puzzlement at the quality and tone of *Pilote de Guerre (Flight to Arras)*, which I definitely did not feel came up to his other work.

The reason became clear. It is the chronicle of a shamed and disillusioned man who, however valiant personally (like hundreds of thousands of other brave Frenchmen, including those in the Resistance and the Gaullist Free French, could not prevent his country from being sold out to the Nazi conquerors by a group of shabby generals, comic-opera mistresses and little monkey-men.

He tried to deny the degradation by snapping that a nation of 40 million farmers could not match in warfare a highly industrialized nation of twice that population. That, of course, was not the point at all. Greece had far less chance of winning the unequal conflict, but she went down fighting and her name shall be forever glorious. I had sense enough not to press the issue or remind him that the English, for example, never give up.

He loaned me a copy of his last book—written for children and illustrated by himself—*Le Petit Prince*. Like certain other books ostensibly for children, this one has deep philosophical overtones for those adults acute enough to find them. The drawings are a delight. I was anxious to secure a copy in the original French for my son, then two years old, whom I had never seen. I would have been welcome to keep his copy, he said, but for the fact that it was somewhat soiled and the only one in his luggage.

A few days later I returned the book on the occasion of a second dinner and soiree at Comte's house. We were assembled in Mme. Comte's studio, the walls of which were hung with some of her sultry Moroccan nudes. A notable painter, she had been trapped in Vichy France on a visit and could not obtain a departure permit to return to Casablanca. Saint-Exupéry seemed to have dropped some of his cares. He did not join in the dancing, but stood by the piano and sang in a sort of half-voice some delightful and amusing *chansonettes*.

He was a little tipsy and a trifle flushed. He sat down at the piano and with an egg in each fist, played chopsticks and other clever trifles with his knuckles. The guests responded with hearty applause.

Later we stood in the poplar-bordered formal garden watching the lights of aircraft landing a few kilometers distant at Cazes Airbase, where soon the distinguished visitor would enplane for New York. A wisp of fog floated by from Pointe el-Hanke and converted Anfa Hill into a detached, floating island. Far to the south and out of sight lay Marrakech, still further the Atlas range and beyond that the Sahara, in whose dim sky lanes I could imagine the laughing shades of Mermoz, Guillaumet and the rest of that gay and gallant band of pioneers so well celebrated by this great poet of the age of flight.

In 1949, after the war, Comte visited me in St. Louis, where I was a faculty member at Washington University School of Medicine. He presented me with a copy of Saint-Exupéry's book of philosophical musings, *Citadelle*. Totally different from his other writings, I found it rambling and disorganized. I have made more than one attempt to read it and find that I cannot.

When I heard that Saint-Exupéry had died in a crash while piloting an aircraft, I was sure that he would not have willed it otherwise; a fitting exit from this life for such a man.

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